Smoking and Ethics: What Are the Duties of Oncologists?

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LEARNING OBJECTIVES

After completing this course, the reader will be able to:

1. Act as a role model to promote patient and community health by abstaining from or quitting smoking and encouraging and assisting patients and colleagues to quit smoking.
2. Assume more responsibility for advocating for smoke-free environments and policies that combat smoking-related health threats in the community.
3. Actively support international policies and interventions that expand tobacco cessation and smoke-free environments.

This article is available for continuing medical education credit at CME.TheOncologist.com.

ABSTRACT

The World Health Organization's 2009 report on the world's tobacco epidemic predicts that, unchecked, tobacco use will kill a billion people in this century. Oncologists have a special professional role to play in combating this epidemic. Based on two views of professionalism, this editorial argues that oncologists have three duties. First,

oncologists should be role models. They should not smoke themselves and urge their colleagues to do the same. Second, oncologists must strongly advise their own patients to stop smoking and advocate for tobacco-free environments in their patients' communities. Third, oncologists have duties to their international colleagues. They should share

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their experience in combating tobacco use with them, encourage and assist them to quit smoking, and help them advocate for smoke-free environments. Further, oncolo-

gists should work to ratify the Framework Convention on Tobacco Control in their own country. *The Oncologist* 2010;15:987–993

THE TOBACCO EPIDEMIC

The World Health Organization (WHO)'s 2009 report on the world's tobacco epidemic continues the alarming story, now much too familiar. In the last century, tobacco killed one hundred million people, and without intervention, it will kill one billion in this century. Tobacco-related deaths kill more people than AIDS, tuberculosis, and malaria together. China alone has 320 million smokers and is the major cigarette consumer in the world, accounting for 37% of demand [1]. Today, 70% of tobacco-related deaths occur in under-resourced countries, and this percentage will rise to 80% by 2030 [2]. Northern Africa, Western Asia, Southeast Asia, and South and Central America are predicted to have a 75%–100% increase in cancer deaths from 2000 to 2020 if the widespread use of tobacco continues at the current rate and if infections like the human papillomavirus and hepatitis B and C are not contained [3]. And there is no sign that tobacco consumption is declining in the under-resourced world; this year, the under-resourced world will consume 71% of all tobacco products [4].

Tobacco is not just killing smokers. About 200,000 workers die each year because of smoke-filled workplaces. Half of the countries in the world, representing two thirds of the world's population, allow smoking in the workplace [4]. Inhaling secondhand smoke increases the risk for lung cancer in nonsmokers by 30% [5]. Nearly half the world's children—700 million—breathe tobacco smoke, often in their own homes. Furthermore, adolescents who grow up in smoking homes are more likely to smoke themselves [6, 7]. In short, "Tobacco use is the most preventable cause of death. Halving tobacco consumption now would prevent 20–30 million people from dying before 2025 and 170–180 million people from dying before 2050 from all tobacco-related diseases including cancer" [3].

What Role Should Oncologists Play?

Oncologists are excellently situated to make great strides against the tobacco epidemic. First, they have the expertise to inform and advise the public and policymakers about the dangers of smoking. Oncologists know the role of tobacco in increasing cancer risk. This knowledge is buttressed by firsthand experience with the consequences of tobacco use. Second, physicians have often played an important role in combating major public health problems. Physicians were instrumental in fighting discrimination in health care in the

Civil Rights Movement in the U.S. [8]. Globally, they were key players in achieving the end of nuclear testing and in the continued fight against nuclear proliferation [9]. International Physicians for the Prevention of Nuclear War started with just six physicians—three from the U.S. and three from Russia—yet their advocacy played a key part in nuclear disarmament [9]. In local communities, physicians have been instrumental in crafting legislation requiring seat belts, child restraints in cars, and helmet use [10]. Advocating against health threats helps to "retain and regain" the public's respect in the medical community [11]. Third, the physician's primary responsibility to his or her patient requires participation in promoting the patient's health in his or her own community. On a commonsense level, it is not reasonable to counsel one's patients about the dangers of secondhand smoke but remain silent about smoke-filled environments that the patient will face in the community. Further, it makes sense that one's expertise determines the health threats a physician should combat. For example, dermatologists may have a special responsibility to advocate for adequate sun protection, trauma physicians for seat belt laws, neurologists for helmet laws, and infectious disease specialists for mandatory vaccination. Oncologists, according to this view, should work for anti-tobacco legislation, because tobacco is a well-understood carcinogen and results in an immense cancer burden.

This commonsense view about an oncologist's responsibility to his or her community is strongly supported by ethical arguments grounded in medical professionalism.

There are at least two views of the basis for the responsibilities associated with professionalism. One is the view that physicians have a contract with society [11]. Society gives physicians access to medical knowledge, entrusts them with care for its sick, and lets them self-regulate their own profession. In return, society expects physicians and the medical profession to safeguard the public's health. As the Medical Professionalism Physician Charter states, "To maintain the fidelity of medicine's social contract during this turbulent time, we believe that physicians must reaffirm their active dedication to the principles of professionalism, which entails not only their personal commitment to the welfare of their patients but also collective efforts to improve the health care system for the welfare of society" [5]. Numerous reaffirmations of medical professionalism expand this responsibility from improving the health care sys-

tem to promoting health in the physician's own community. The American Medical Association's 7th principle of the Code of Ethics states, "A physician shall recognize a responsibility to participate in activities contributing to the improvement of the community and the betterment of public health" [12]. The Association of American Medical Colleges Core Curriculum states that physicians "must use their influence to improve the health of the communities where they live and practice" [13].

A second view of professionalism grounds a physician's responsibilities in the Hippocratic tradition that considers medicine a practice or art that strives to uphold certain values. For Hippocrates, the key value was benefiting the sick [14]. The physician must not only be technically competent, he or she must uphold the values of healing. The word "profession" literally means "to profess," and each medical student who takes an oath at graduation enters the profession as he or she professes to uphold health values, including presumably "working internally and externally to right wrongs that make good healthcare difficult" [15]. Of note, there are no boundaries to this obligation to uphold health values. Whereas the view of professionalism as a contract with society can be interpreted to extend just to one's own society or community, the duty to uphold health values may extend beyond one's community's borders.

Both these views of professionalism reinforce the idea that a physician's duty at least includes combating health threats to his or her own patient in the patient's own community, though much broader claims have been made [16]. Each as well hints at another duty—to educate one's colleagues. Under the first view of professionalism, the contract that establishes the medical profession includes the responsibility for medicine to be self-regulating, setting standards for joining the profession (licensure today) and holding professionals to the standards of the profession. Implied in this responsibility to one's colleagues is the responsibility to support them, educate them, mentor them, and set a personal example for them. In the second Hippocratic view of professionalism, the physician is indebted to his teachers and has a duty to teach the teacher's sons and "other pupils who have signed the covenant." Again, physicians are responsible for teaching one's colleagues. In short, we argue that oncologists' responsibilities extend beyond treating one's own patients, to advocating for their patients' health in their own community as well as supporting and educating one's colleagues about tobacco control.

Let us explore three duties related to the global health threat of tobacco use that arguably result from these views of professional responsibility.

AN ONCOLOGIST'S DUTIES

Be a Role Model: Abstain from Smoking and Urge Your Colleagues to Do the Same

The Data

Multiple studies have shown that physicians who smoke are less likely to counsel their patients against smoking and to assist their patients in smoking cessation [17–20]. It is not surprising that a physician smoker may be conflicted and is less likely to offer the advice and assistance to his or her patients for smoking cessation. This is critical, because providing cessation assistance is considered standard of care. Eliminating this conflict by ceasing to smoke could contribute to improving a physician's patient care.

Must Physicians Be Role Models of Healthy Living?

The Hippocratic view arguably requires that physicians be role models of healthy living. The practice of medicine is one of the three classic professions, along with law and religion. Lawyers and religious leaders are required to uphold the values of their profession in their personal lives—lawyers the value of law and religious leaders the values of their faith. Lawyers and religious leaders risk being removed from their profession if they personally act contrary to these values. So what is required of physicians who profess the value of health? It may be hard to identify exactly which health risks are so egregious that a physician must avoid them in order to profess and live in accord with health values. There certainly is a continuum—obesity, sun exposure, eating processed meats, cycling without a helmet, never exercising. Should obese physicians receive mandatory weight reduction interventions and lose their licenses if they do not successfully lose weight? How about physicians who drink in excess, even if they are careful so that their drinking does not impact their patient care? Or what if physicians avoid fish and omega-3 fatty acids and instead eat smoked and cured meats every day? At what point is an unhealthy lifestyle such a breach of a physician's responsibilities that a professional physician must not live such a lifestyle? We do not suggest an answer here, acknowledging that the exact line is difficult to draw [21]. But the difficulty of drawing just the right line does not imply that no line should be drawn. As Supreme Court Justice William O. Douglas stated, "It is no requirement . . . that all evils of the same genus be eradicated or none at all" [22]. We contend that using tobacco products is an absolutely clearcut danger to health with no lifestyle benefits. Even if one can argue that a trauma surgeon who loves the feel of the open road can ride a motorcycle responsibly, we cannot conceive of any such argument for an oncologist and smoking. Simply,

the use of tobacco products is “over the line,” and no one knows this better than oncologists. In order to profess health values, at least oncologists *are professionally obligated* to abstain from tobacco consumption.

Strongly Advise One’s Own Patients to Stop Smoking and Advocate for Tobacco-Free Environments in Your Patients’ Community

Advising patients about the health risks of smoking is the standard of care [11]. A great deal of research and policy has been devoted to increasing clinical interactions aimed at tobacco control. The 2008 Clinical Practice Guidelines [23] highlight that health care providers should consistently identify and document tobacco use status, treat every tobacco user seen, and encourage every patient willing to make a quit attempt to use the recommended counseling treatments and medications. The Guidelines highlight that individual, group, telephone, and quitline counseling are effective, with effectiveness increasing with treatment intensity. In addition, medications for tobacco dependence (bupropion SR, nicotine gum, nicotine inhaler, nicotine lozenge, nicotine nasal spray, nicotine patch, and varenicline) are effective and should be promoted, except when medically contraindicated. Moreover, the combination of counseling and medication is more effective than either alone. Finally, if patients are unwilling to make a quit attempt, clinicians should use motivational treatments to increase future quit attempts. Thus, the Clinical Practice Guidelines clearly articulate the role of clinicians in promoting cessation.

One third of cancer patients continue to smoke after their diagnosis, resulting in lower treatment effectiveness, more adverse side effects, a higher likelihood of a second malignancy, and a shorter survival time [24–28]. Further, receiving a cancer diagnosis is a “teachable moment” when patients may be more open to this advice and counseling [29]. In fact, most patients with a smoking-related cancer stop smoking or make serious efforts to quit at the time of diagnosis [30–33]. Even patients who continue to smoke may remain motivated to quit. In a group of stage I small cell lung cancer patients, almost 90% had made one or more attempts to quit smoking, though 60% of survivors still smoked at 2 years [31]. Although oncologists do an excellent job of documenting smoking behavior, they fall short in advising their patients to quit, providing such advice for only about 25% of their patients [34]. Given the Clinical Practice Guidelines [23], it is clear that much more effort must be exerted toward cessation, especially among this patient population.

It must be noted, however, that a large randomized Eastern Cooperative Oncology Group [24] trial did not demon-

strate higher smoking abstinence in patients whose physicians followed the National Institutes of Health’s smoking cessation guidelines [35], compared with a standard of care control group. The intervention group received a brief 5-minute discussion of the benefits of quitting, an agreed upon quit date, and a prescription for nicotine replacement therapy. The investigators suggested that this negative result may be because of the ethical requirement that the control group receive whatever nonsmoking advice and intervention their physicians normally provides. However, it may be that, for an oncologist to meet his or her duty to assist patients in smoking cessation, a higher intensity intervention may be required, as suggested by the Clinical Practice Guidelines. For example, successful interventions may require more intensive behavioral interventions in combination with pharmacotherapy and follow-up to encourage compliance with prescribed pharmacotherapy [36]. In addition, insurers and purchasers should ensure that all insurance plans cover effective counseling and medication; tobacco dependence treatments are cost-effective and providing coverage for these treatments increases quit rates [23]. In the U.S., the Centers for Medicare and Medicaid Services now allow reimbursement for intensive counseling [34], blunting the claim that clinicians are not appropriately compensated for the time necessary to perform this task. Health care providers, particularly oncologists, should support movements toward greater coverage for cessation services by all insurance providers.

To protect one’s own patients and to prevent cancer, oncologists must also advocate that all public places be smoke free. Smoke-free environments eliminate the dangers of secondhand smoke, which are well documented [37]. We understand that such political advocacy is not normal practice for many oncologists, but this duty stems directly from one’s duty to one’s own patients and potential patients. Nor need this advocacy be onerous. An Internet assessment of one’s own community’s laws and an e-mail to one’s elected representative as a professional dedicated to preventing and reducing cancer may be helpful. Certainly oncologists must counsel their patients about the dangers of secondhand smoke in confined places. In the U.S., there are still two areas of concern—the home and automobiles. As a result of, in large part, the progress in creating smoke-free environments in the U.S. over the past two decades, the home is now a primary source of exposure to secondhand smoke for both children and nonsmoking adults [38]. In the U.S., the prevalence of smoke-free homes has increased rapidly in recent years—from 1992 to 2008, the proportion of smoke-free homes increased from 43% to 78% [39, 40]. Unfortunately, however, there continues to be a great need to promote smoke-free homes, internationally and in the U.S.

in low socioeconomic homes and homes where smokers live. Not only do smoke-free home policies reduce secondhand smoke exposure, but smoke-free homes lead to less use of tobacco in both adolescents and adults [6, 41]. Last, automobiles provide another high-risk environment for secondhand smoke exposure, with the concentration of smoke in automobiles from one smoker being roughly at the level found in bars that allow smoking. The oncologist should be alert to any such proposed legislation, and should at least advocate for laws that forbid smoking in cars in which children are occupants [42].

In general, advocacy for smoke-free environments, when successful, directly combats the tobacco epidemic. A smoke-free workplace reduces employee tobacco consumption by 29% [43]. California achieved a lung cancer drop of 2.8% between 1996 and 2005, double that of other states, possibly because of their strong anti-tobacco laws [2]. New York City achieved an 11% drop in smoking in 2003 with strong policies such as increased cigarette taxes, smoke-free legislation, and intensive public education [44]. The Centers for Disease Control and Prevention [45] have highlighted several policy interventions and programs that promote tobacco control, including increased taxes, increased smoke-free policies, regulating tobacco advertising, limiting youth access to tobacco, and increasing access to cessation resources. Thus, promoting smoke-free policies is one of several policy changes that are critical to tobacco control.

Duties to International Colleagues

Professionalism includes duties to one's colleagues, and in today's world, the colleagues we interact with, and may even share patients with, are found around the world.

Share Your Experience

If you have an effective smoking cessation program, education campaign, or successful way of achieving smoke-free environments, publish your results and share them openly with colleagues. Doing so increases our repertoire of evidence-based interventions and programs. Moreover, implementing evidence-based programs when possible and sharing experiences in adapting them to new contexts are important methods of disseminating research and practical experiences.

Encourage and Assist Your Colleagues to Quit Smoking

The smoking incidence is increasing in the under-resourced world, and the prevalence of physicians who smoke is high in many countries. For example, a 2004 survey of 3,552 Chinese physicians found that 41% of male Chinese physicians smoked, with 37% of the smokers smoking at work in front of their patients [20]. The WHO reported an even

higher percentage, with 61% of Chinese male physicians smoking, followed by 55% of Bosnian, 43% of Korean, 41% of Russian, 38% of Saudi, and 37% of Spanish male physicians smoking. As a comparison, only 3% of American and 8% of U.K. male physicians smoke [46]. In some countries, smoking is a culturally supported practice, so culturally relevant ways of discouraging physician smoking are needed [47]. Helping our international colleagues to quit smoking may involve helping them find nicotine replacement therapy or behavioral interventions to support cessation. The 2008 WHO Global Report on the Tobacco Epidemic identified 39 countries where it is impossible to obtain nicotine replacement therapy even if the individual can afford it [1].

Help Your Colleagues Advocate for Smoke-Free Environments and Support Ratification of the Framework Convention on Tobacco Control

Many oncologists live in communities that entirely lack tobacco control. The WHO states that "only 5% of the world's population lives in countries with full protection and anti-tobacco laws" [1]. Educating and supporting one's colleagues to work in their own communities to establish tobacco-free environments is one of the oncologist's professional duties.

A concrete way of helping is to urge fellow oncologists to lobby their governments to ratify the Framework Convention on Tobacco Control (FCTC). To date, 168 countries have ratified this plan for tobacco control. A key outlier is the U.S. [34]. Once ratified, the FCTC will provide an excellent blueprint for governments to combat the use of tobacco by increasing tobacco taxation, banning tobacco advertising and promotion, prohibiting smoking in public places and worksites, implementing effective health warnings on tobacco packaging, improving access to tobacco cessation treatment services and medications, regulating the contents and emissions of tobacco products, and eliminating illegal trade in tobacco products. It also provides for the sharing of scientific, technical, and legal expertise across borders. In the U.S., the Bush administration signed the treaty but did not ratify it. To date, President Obama has yet to send it to the Senate for ratification. It is imperative that the U.S. play a leadership role in the global effort to reduce tobacco use. If ratified and effectively implemented globally, the tobacco treaty will be a fundamental turning point in reducing tobacco use and buffering its consequences. Thus, the medical community, particularly oncologists, should be involved in supporting this pursuit.

BEYOND THE CALL OF DUTY—HELPING UNDER-RESOURCED COUNTRIES

We have not yet reached the pinnacle of the tobacco epidemic; the effects of the current increase in smoking in under-resourced countries will be realized as current smokers reach middle age. But even now, 72% of cancer deaths occur in low- and middle-income countries [48]. For example, in several decades there will be a million new cases of cancer in Africa every year. Yet, African countries lack basic cancer services, such as screening, radiotherapy, and palliative care. The tobacco epidemic in Africa is exacerbated by the prevalence of viral infections and poor nutrition, all contributing to the increasing cancer incidence. Without improvements in basic services and active tobacco cessation programs, in 2020 there will be 804,000 new cases of cancer in sub-Saharan Africa alone, with 626,400 people dying that year [49].

Is it every oncologist's duty to address this disparity? No, but certainly some will be able to act beyond the call of duty, particularly working through their institutions and professional organizations. St. Jude Children's Hospital in Memphis, Tennessee, provides an excellent example of what an institution can do to alleviate cancer suffering in under-resourced countries. St. Jude "twins" with under-resourced children's cancer programs internationally, providing funds, training, and support for the first few years to upgrade the treatment of childhood cancers. Simultaneously they start a local foundation with the goal of creat-

ing self-sustaining programs for cancer control supported by local philanthropy. They have successfully twinned with hematology/oncology units throughout Latin America [50]. Institutions that could partner with hospitals in Africa could have a positive effect in improving cancer services. And there are multiple professional, governmental, and nongovernmental organizations that provide opportunities for individual oncologists to share their skills and time to combat global cancer and the tobacco epidemic.

CONCLUSION

Oncologists may have considered activism against tobacco use to be laudable but optional, to be accomplished by the good samaritans among them. We argue that quitting or abstaining from smoking, advocating for smoke-free environments in one's own community, and actively supporting one's international colleagues to do the same are duties, grounded in both common sense and in the ethics of professionalism. These duties are neither onerous nor optional, and can yield impressive results. Oncologists need to do their part so that we will not experience in this century the devastating tobacco epidemic predicted by the WHO.

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