Cigarette Smoking and the Responsibility of the Hospital Physician

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It is right that this conference which has demonstrated so many aspects of the care of chest and heart disease should devote one session to their commonest preventable cause—cigarette smoking. In this matter we cannot leave prevention to the Public Health authorities. They indeed can legislate for clean air in our cities—but this is of limited use if half our citizens insist on the pollution of their private air supplies. Legislation alone cannot change private habits. But we as personal physicians are in a privileged position and can have a very powerful influence on our patients if we care to use it.

The hospital physician has a special responsibility since the diseases caused by cigarettes bring a considerable burden to the hospital service. In England and Wales over 4 percent of our hospital beds are needed every day to care for the cigarette-induced cases of chronic bronchitis, coronary disease and bronchial carcinoma. About 8,000 hospital beds are occupied because of cigarette smoking, or the equivalent of all the beds in the 12 London University Teaching Hospitals. Every large hospital is devoting about 30 of its beds to treat the results of cigarette smoking. This is an extravagant waste of our resources of both staff and equipment which we cannot afford.

Prevention is all the more important since there is comparatively little we can do for these patients on diagnosis. Over one-third of our patients die in their first coronary attack, and only 5 percent of our lung cancer patients survive five years. By the time the patient with chronic bronchitis or emphysema comes to the hospital, he is usually severely and permanently crippled. As hospital physicians each of us has three responsibilities in this matter:

1. To help our patients to stop smoking.
2. To control smoking in our hospitals.
3. To encourage the reduction of cigarette smoking in the community.

Antismoking Clinics

Antismoking or tobacco withdrawal clinics have been used in many countries. So far their results have proved disappointing, although much valuable information has been obtained. Clinics open to the public appear to attract the anxious addicted smoker—the person who has repeatedly tried to stop but invariably failed.

Overall results from such clinics show that on an average about 20 percent are still successful at one year. Nevertheless we should not underestimate such modest successes which may save more lives than our efforts to cure the cigarette-induced diseases.

In an antismoking clinic which we ran in London in which 27 percent of the patients were not smoking at one year, I estimated that it took between three and four hours of a doctor’s time for each successful patient. When I recounted this to a psychiatrist recently he replied that if he had obtained a positive result with one of his patients after three or four hours he would have been very pleased!

In those clinics run for patients with cigarette-related diseases the results are usually much better. Mikhail (1970) found that 59 percent of a group of 72 patients with chronic bronchitis were not smoking at three years. In our London diet trial for patients with a myocardial infarction the 317 smokers were all advised to stop. Of these 39 percent were not smoking at a mean follow-up period of three years.

Wilhelmsen (1970) from Gothenberg found much better results in his myocardial infarction patients than in those attending his Antismoking Clinic.

I conclude that in a hospital setting an antismoking clinic may well be of value for patients with chronic bronchitis or coronary heart disease, especially if combined with other advice on the control of their disease. Much more research is needed to determine the value of open clinics.

Controlling Smoking in Hospitals

Many hospital committees have debated whether smoking should be allowed on their wards. Thirty years ago smoking was usually allowed only after meals. Today more liberal rules about visiting hours have often accompanied a greater permissiveness on smoking. This is quite paradoxical, since today we know so much more of the perils of cigarette smoking.

For 20 years smoking has not been permitted on the wards in the Central Middlesex Hospital which mainly admit patients with chest or heart disease. Complaints from patients have been few and many appreciate the help this rule gives them to cut loose from the habit even though they have been hardened smokers for many years. The fresher air in the ward is much appreciated by nonsmokers.

For too long have we accepted the ‘‘right of the individual’’ as meaning the ‘‘right of the smoker,’’ the right to pollute not only his own but other patients’ atmosphere.

I am convinced that a ‘‘No-Smoking’’ ward is both possible and effective and chest physicians in particular should ensure such an environment for their patients.

The Sale of Cigarettes in the Hospital

The hospital should clearly lead public opinion in the matter of cigarette smoking. Most hospital shops sell cigarettes freely both to patients and staff although some have forbidden their sale. Cigarettes should certainly not be sold to patients while in bed and vending machines should not be allowed on hospital premises. Cigarettes should really not be sold in hospital shops—though this last is a more difficult measure to implement. Allowing their sale implies the approval of cigarette smoking, and this is inconsistent with health objectives. It is time that hospitals followed the lead of many large stores and theaters in prohibiting smoking, except at very limited times or in segregated places.

Smoking Habits of Doctors and Students

The massive defection of doctors from cigarette smoking has been one of the most encouraging features of the recent medical scene. Associated with this change has been a considerable fall in mortality rates for doctors compared with other men especially for lung cancer and bronchitis as is shown in Table 1.

Since doctors who smoke are generally more permissive in their attitude to the smoking habits of their patients, it is clearly important to reduce still further the number of smoking physicians. Doctors who smoke seriously lessen the effect of any campaign of public health education.

We should also consider the position of medical students, exposed as they are to the conflicting

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<tr>
<td>Lung cancer</td>
<td>+ 7%</td>
<td>-38%</td>
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<td>Bronchitis</td>
<td>- 4%</td>
<td>-24%</td>
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<td>All cardiovascular disease</td>
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pressures of society and their profession. A recent survey of British medical students' attitudes to smoking showed that nearly half the medical students in England and Wales smoke cigarettes, and this compares with about a quarter of all doctors who smoke them (Bynner 1967). We must ask if the teaching of students on smoking is adequate. Less than half these students were aware that lung cancer causes more deaths than road accidents, although it actually causes four times as many. Medical students, in fact, performed little better than students from other faculties. Only half the students had been discouraged from smoking during their medical course and only one half were convinced that they should advise their patients not to smoke, or that they themselves should set an example to their patients by not smoking. This shows that students need clearer and more effective teaching on the results of cigarette smoking, and this policy has been accepted by my own medical school. But the lesson learned from seeing one patient with chronic bronchitis in respiratory failure may be more eloquent than a book full of statistics.

COMMUNITY RESPONSIBILITY

The chest and heart physician is the best informed individual on the effects of cigarette smoking and to him falls a wider challenge—the control of smoking in the community. Immersed as he is in clinical medicine, he has often left this task to others whose voices may be less informed and less powerful than his own. He must make his voice heard and insist that, just as he attempts to control cigarette smoking in his own patients, so should the Public Health and Education services of his country undertake to control smoking in the country at large. Most countries have well developed Tuberculosis Services which have resulted in a rapid fall in death from this disease. By contrast there are no countries with an effective program for the control of smoking. Yet in England for every death from tuberculosis there are 20 deaths from cigarette smoking.

As physicians we must be the pacemakers in the community's effort to control cigarette smoking. But we need the help of many others—the teachers, the sociologists, the economists, and, of course, the legislators.

In this we should follow the excellent example of the United States whose Interagency Council on Smoking and Health has become a powerful instrument in combating cigarette smoking. Each country needs such a body to coordinate the efforts of different disciplines.

We even need to recognize the problems of the Tobacco Industry—for they do have a very real problem in marketing a lethal product which must inevitably become unacceptable to the public.

We should press that each national Public Health Service should employ at least one experienced physician with supporting staff whose full-time responsibility is the control of cigarette smoking.

In summary, we hospital physicians have a real responsibility in this matter. Each one of us, whether with patients, with students or, particularly, by our own example, can hasten the day when cigarette smoking ceases to be the major health hazard to our patients.

REFERENCES

1 Mikhail J: Personal communication, 1970
2 Wilhelmsen L: Personal communication, 1970
3 Bynner JM: Medical students attitudes towards smoking. Government Social Survey, 1970
4 Fletcher CM, Horn D: Report to 23rd World Health Assembly, 1970

From Scratch . . .

It is from the polar bears that the Eskimos have learned their skill in hunting seal. They watched the way the bears would linger around the hole in the ice where a seal was due to come for air every seven or eight minutes. The seal cannot resist breaking surface to find out the reason for the smallest noise, and the bear makes the most of this. He scratches the edges of the hole with his claws, gets out of the way and, when the seal emerges, hogs it in his huge paws and sinks his claws in his neck. Then he drags his victim out onto the ice. The Eskimos copied the bear's behavior. They make an imitation paw out of a reindeer horn or a sea-lion's tusk with a bear's claws fastened to it. The hunter then scratches the ice with this decoy, imitating the rhythm used by the bears, and then withdraws, holding his harpoon at the ready. As soon as the seal's head pops inquiringly through the ice, there is a swift movement and the dart finds its mark.