



Advocating for the Nicotine-Addicted Patient: Duty of Care and Negligence

Renee Bittoun,^{1,2} Karl-Olov Fagerstrom,³ John Baker⁴ and Colin Mendelsohn⁵

¹ Smoking Cessation Unit, Faculty of Medicine, University of Sydney, Australia

² Editor, *Journal of Smoking Cessation*, Australia

³ Smoker's Information Centre, Helsingborg, Sweden

⁴ Psychiatrist in private practice, Sydney, Australia

⁵ General Practitioner, and Editor of *Your Health Newsletter*, Sydney, Australia

Tobacco dependence is a treatable disease now recognised by the WHO and DSMV as nicotine addiction. Nicotine addiction varies in degrees of severity reflected in the ICDC (International Classification of Diseases Codes) that codes tobacco use as : Current Use, Harmful Use — Not Dependent, and Tobacco Dependence Syndrome with Mental and Behavioral Disorders due to Tobacco (WHO, 2010). The neuropsychobiology of nicotine dependence is complex (Markou, 2008), and, due to the varying intensity of this disease, not all smokers need help, and there is not a one-size-fits-all solution for those who do (Benowitz, 2008).

In recent comments Chapman (2009, 2010) suggests that smokers are being discouraged from quitting 'cold-turkey' and, because of the promotion of pharmacotherapies, 'unassisted cessation is rarely researched, instead framed in studies often funded by the pharmaceutical industry as a challenge to be eroded by persuading more to use drugs.' Smokers are attempting to quit en masse in most western countries. One in two smokers tries to quit each year and most attempts are unassisted. However, Chapman ignores the fact that the unassisted quit rate is only 3–5% after 6–12 months (US Department of Health and Human Services, 2008). This is discouraging for the smoker and health professionals. Given the devastating health effects of smoking it is incumbent upon us to try to make every quit attempt a successful one.

While it is important to provide preventative public health strategies, this should not occur at the exclusion of individualised treatment for those who need it. This is unethical and unjustifiable now that specific treatments for tobacco dependence are available.

Registered pharmacotherapies for smoking cessation undergo multiple double-blind placebo control studies (as with all other medications) and are vigorously scrutinised by ethics committees at the institutions at which they are carried out.

Public criticisms should surely be made of the many unregistered and unproven smoking cessation therapies in the public arena, where grossly unsubstantiated claims of efficacy attract a vulnerable and gullible proportion of smokers every year.

If a society makes such a harmful substance as tobacco legally available it has a responsibility to provide medical services for those affected adversely by it.

If there are more effective valid quitting methods available, why not use them?

If the patient has a significantly increased chance of quitting with pharmacotherapy it is negligent not to offer it.

We understand and have written (Bittoun & Bowning, 2005) that cessation intervention is not an either/or of 'tobacco control vs clinical intervention'.

Optimal outcomes would be achieved by using both strategies in unison.

In a humane and civilised society, given the medical repercussions of tobacco smoking, it is our duty of care to help smokers achieve the best possible chance of quitting. To do otherwise would be medically negligent.

Disclosure

The authors of this editorial have, from time to time in their careers received funding from pharmaceutical, governmental and other institutions for smoking cessation interventions.

References

- Markou, A. (2008). Neurobiology of nicotine dependence. *Philosophical Transactions of the Royal Society B: Biological Sciences*, 363(1507), 3159–3168. doi:10.1098/rstb.2008.0095
- Benowitz, N.L. (2008). Clinical pharmacology of nicotine: Implications for understanding, preventing, and treating tobacco addiction. *Clinical Pharmacology & Therapeutics*, doi:10.1038/clpt.2008.3

Bittoun, R., & Bowning, C. (2005). Tobacco dependence, smoking prevention and cessation. In C.J. Bowning and S.A. Thomas (Eds.), *Behavioural change: An evidence-based handbook for social and public health*. Oxford: Churchill Livingstone.

Chapman, S. (2009). The inverse impact law of smoking cessation. *Lancet*, 373, 701–703.

Chapman, S. (2010). *Smoking racket*. Available at www.abc.net.au/unleashed/stories/s2815273.htm

US Department of Health and Human Services. (2008). *Treating tobacco use and dependence: Clinical practice guideline*. Available at www.surgeongeneral.gov/tobacco/default.htm; June 2008

World Health Organization (WHO, 2010). *International classification of diseases (ICD)*. Available at <http://www.who.int/classifications/icd/en/>

