Leading Article

Smoking – the doctor's opportunity

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Introduction

The decline in smoking in the UK in the past ten years has been one of the great successes of preventive medicine. In 1971 a DHSS report concluded that a 20% fall in cigarette consumption would result in the saving of 8,000 premature deaths each year after 10 years. The fall in cigarette consumption in the past 10 years has in fact been 26%. This mass change in public behaviour has led to many fewer deaths from coronary heart disease (CHD), chronic bronchitis, lung cancer and other diseases, although the full effects have not yet been achieved.

Major past successes of preventive medicine have resulted from public health legislation to ensure safe water, pure food and more recently clean air, combined with improved housing. By contrast, change in man's behaviour is needed to control today's main causes of death and disease; these include affluent eating, sedentary living, dangerous driving and cigarette smoking. Unfortunately unhealthy behaviour is too often stimulated and promoted by vested interests and to control them may also require legislative action, such as by banning cigarette advertising or by requiring food labelling. Legislation on seat belts is already saving many lives and serious injuries.

Although the figures of smoking trends are encouraging, cigarettes remain a major health problem. There are more than 6 million children at school in the UK. If present habits persist at least 2 million will become cigarette smokers and about one in three of them will die prematurely from cigarette related diseases. We are rightly concerned at those who die from heroin addiction or glue sniffing or when one child in a 100,000 has a fatal reaction to pertussis vaccine. Yet too readily do we accept the far greater numbers who will die prematurely from cigarette smoking if we are not successful in reversing the trend. A member of parliament with an average sized constituency will lose 60–70 men and women each year from smoking related diseases. The cost to the

NHS of smoking is around £170 million a year. This means that on average each district health authority (DHA) spends about £800,000 yearly directly on the health consequences of smoking. It has been estimated that at least 30 beds are occupied with smoking related diseases in the average district hospital. Yet some hospitals still sell cigarettes in their hospital shops and have cigarettes on sale from trolleys visiting medical, surgical and obstetric wards. Doctors Perkins and Dick (1985, this issue) have confirmed the findings of several other workers that those who stop smoking after a myocardial infarction are half as likely to have a fatal relapse as those who continue to smoke. No beta-blocker, anti-coagulant or surgical measure can match these figures. Yet too few patients are given help to stop smoking in hospital and are not actively followed up to assure success.

Every year evidence of yet further smoking related diseases is published. Renal artery stenosis, carcinoma of the pancreas, polycythaemia, and others may all be related to cigarettes and further evidence of the potential risk of passive smoking accrues. Doctors have shown that as a result of stopping smoking their mortality from cigarette related diseases has sharply declined. What action then can doctors take to reduce the disease rates caused by tobacco in the UK which has the highest mortality from cigarettes in the world?

Individual action

Doctors, especially general practitioners can be very effective. Russell and his colleagues have shown that, in the course of every day practice, the average doctor, advising each smoker to stop, providing an appropriate leaflet and requesting a return visit, can help 25 patients to become non-smokers each year (Russell *et al.*, 1979). A heart attack is probably the most effective stimulus for stopping and those who do so can halve the subsequent relapse rate, yet at least half smokers fail to do so, as Perkins and Dick have shown. The improved prognosis in those who do stop

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may be even better than recorded since studies testing for carboxyhaemoglobin or urinary thiocyanate have shown that up to a quarter of patients who say they have stopped have not actually done so.

Although the shift in public opinion favouring non-smoking supports those who try to stop, better methods are certainly needed to help them. Some have found nicotine based chewing gum helpful provided it is accompanied by maximum psychological support as may be given in some smokers' advisory clinics. Its routine prescription by general practitioners without such support seems to be ineffective. Better results are likely where all members of the health team, including nurses, receptionists and health visitors are all motivated to give support. The ASH/HEC Give Up Smoking package has been widely and effectively used in general practice.

District action

Each DHA should have a policy for smoking control as outlined in the Health Promotion Guide for the NHS published by ASH. This should include a policy for non-smoking in all acute medical, surgical and obstetric wards with limited 'Smoking Allowed Areas' situated away from wards and day rooms; a ban on cigarette sales in hospital shops, and agreed non-smoking in all health committees. Health centres, like hospitals, should have a sign at their entrances stating 'You are entering a no smoking zone.' All NHS canteens should provide smoke-free sections.

National action

The Royal College of Physicians and British Medical Association have done much to press an unwilling government to take much stronger action to curb cigarette smoking. Both have pressed for a ban on cigarette advertising and sports sponsorship by the tobacco companies.

Their efforts might be more effective if MPs were

made more aware of the problem; doctors could assist their understanding by inviting them to visit hospitals so that they could see for themselves the tragedy of premature deaths from tobacco related diseases. Ealing MPs were informed that it was estimated that in 1979, 504 deaths were due to smoking related diseases. This type of information could motivate MPs to press for much stronger government action.

International action

Sadly Britain not only leads the world in rates for cigarette induced diseases but is responsible for spreading the habit to many developing countries. Three of the world's six largest tobacco companies are based in London, including British American Tobacco which is by far the largest exporter to or promoter of tobacco growth in the Third World. Health authorities and individual doctors should examine their investments and their consciences when considering these facts. Lung cancer is becoming one of the main causes of cancer death in countries such as India, China, Brazil and the Bantu races of South Africa. Coronary heart disease is a major cause of mortality in Pakistan and the Phillipines.

Conclusions

Cigarette smoking remains one of the main causes of preventable disease in the UK. One in three smokers will eventually die prematurely because of this habit which is responsible for around 100,000 such deaths each year.

Although government could and should do much more to help to discourage the habit, the medical profession still has a major responsibility in assisting patients to stop and in encouraging a smoke free environment in all health service premises. Two recent studies have shown that only 13% of doctors now smoke cigarettes (Doll, 1983; Hallett, 1983). Perhaps we should all do more to preach what we practice.

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