"Have you considered taking up smoking?": a thought experiment

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I recently met an epidemiologist who has an interest in drug-taking in primary care. He is planning to study why so many people take long term benzodiazepines, when all the guidelines say they should not, and family physicians expend so much energy trying to persuade them to stop. He hopes to find out whether such patients actually consider themselves to be addicted, or if they feel they have a habit that does them more good than harm. He is also interested in whether patients who stop benzodiazepines think that doing so has improved their lives rather than actually making them worse.

This kind of study would clearly go against the grain, by avoiding the discourse of "addiction", "misuse" and "dependency" that pervades the medical literature,[1] and looking instead at the perceptions of users. The information that emerged from a non-judgemental approach like this could be very useful. It might help doctors to take a more evidence-based approach towards counselling benzodiazepine users, and to achieve more success in weaning them off. It might also have another, more paradoxical effect. The results could challenge prevailing medical assumptions about what is right and wrong in the use of habit-forming drugs. It could liberate doctors from the frustration they sometimes feel when attempts to withdraw benzodiazepines fail, as well as helping them to recognise when long term use could be regarded as a relative success. It might also lead to a more subtle discussion that acknowledged the rationality of seemingly irrational choices more generally.

The conversation led me to recall a heretical thought I have sometimes had about another habit-forming drug, namely tobacco. In a general practice setting, I have often seen anxious people who do not smoke but could no doubt relieve their anxiety on stressful occasions by doing so. Mischievously, I have sometimes wondered what would happen if I asked the question "Have you considered taking up smoking?". The question is so eccentric that most doctors would be aghast at the thought of asking it. If anyone did so, it might even lead to a complaint. As a thought experiment, however, the question raises some interesting issues. It highlights the strong preference that doctors have for measuring harms rather than benefits. It also draws attention to how often we make implicit assumptions about the balance between the two, without asking if patients agree with them.

ENCOURAGING TRANSPARENCY

Could we check out these assumptions more transparently with patients? There are two clinical approaches that could offer some guidance here. One is "motivational interviewing", an approach to health promotion based on respectful negotiation, rather than by advice and persuasion.[2 3] Among its tools is the "motivational balance sheet".[4 5] This allows a physician or psychologist to ask a patient to make a list of the advantages of a habit such as smoking, drinking or lack of exercise, before setting down the disadvantages. The patient is also asked to list the disadvantages of giving it up, before thinking about the gains. The process certainly allows people to describe the pleasures they derive from a behaviour that may be doing them harm. It lets the professional and client agree, if necessary, that "this is not the right time to try to stop". However, the technique is still based on an underlying assumption that there is a "good" outcome and a "bad" one. Unless the professional is exceptionally open-minded, it does not really acknowledge that, for some people, an "adverse" habit may bring so much pleasure, or at least relief, that they have no serious intention of ever doing anything about it.

In some branches of psychotherapy, there is a similar tradition of asking challenging questions, but in a more provocative way.[6 7] This includes posing questions like "If you suddenly decided to give up being an addict, who else in your family do you think might take on that role?" In theory at least, these questions are supposed to help family members become more aware of their pattern of interaction, and they no doubt prompt some people to realise they are caught up in particular roles, and have a choice about whether to maintain these. However, unless such questions are asked with respect and good humour, they can seem sarcastic, manipulative or even cruel. As a result, they have largely gone out of fashion.

Perhaps the most transparent approach of all would be to acknowledge openly how many people make use recreational or prescribed drugs, alcohol or tobacco, with the conscious intent of relieving unpleasant states of mind, or inducing desirable ones. Such patients have not necessarily ignored future risks. They may simply have chosen to discount these, in order to cope with the struggles of everyday life more easily. Many doctors make exactly the same choices in private, even if they compartmentalise these from their professional advice-giving. In many cultures and eras, mind-altering substances have been regarded as a blessing because of the emotional relief they bring, and have played an important part in communal celebrations and rituals. One also does not have to go back far in time to discover how doctors have extolled the boons of virtually everything they now condemn. Perhaps if we could be less moralistic about substance use, and apply the same scientific curiosity its benefits as we do to its harms, we would be better at helping people make the right choices for themselves – whether this means continuing to take drugs like benzodiazepines and tobacco, or stopping them.

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