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It’s time to treat smoking as an addiction

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The recent 50th anniversary of the landmark U.S. Surgeon-General’s report on smoking provides a good opportunity to reflect on how far we’ve come in the war on tobacco, as well as how far we have left to go.

Half a century ago, more than half of Canadian adults smoked: 61 per cent of men and 38 per cent of women. That rate has plummeted to 17 per cent today. Yet the cost in lives and in dollars remains staggering.

In Canada, there are some 40,000 smoking-related deaths annually: more than 20,000 from lung cancer, another 11,000 from heart disease and stroke, and 8,000 from chronic obstructive pulmonary disease (COPD). Second-hand smoke alone kills an estimated 800 people a year.

Tobacco remains the leading cause of preventable illness, disability and death, its economic impact an estimated $29-billion annually.

We know a lot about the damage wrought by smoking on individuals as well.

Tobacco smoke is made up of more than 7,000 chemicals, including cyanide and carbon monoxide, and 60 cancer-causing agents. It affects not only the heart and lungs, but also every organ in the body, and the long list of diseases caused by exposure to tobacco smoke continues to grow.

So why do one in seven adults still smoke?

They smoke to relax, because they enjoy the taste, to pass the time, to do something with their hands, to be sociable. But the bottom line is that they continue to smoke because they're addicted. (The really addictive substance in tobacco is nicotine.)

Everybody who smokes knows it's bad for their health. The vast majority of them desperately want to quit. But quitting – even trying to quit – is highly uncomfortable.

Yet the way we try to get people to butt out is almost exclusively through education – everything from fridge magnets to earnest YouTube testimonials.

"We have educated the bejeezus out of them," says Dr. Andrew Pipe, the chief of the division of prevention and rehabilitation at the Ottawa Heart Institute.

He says the smoking-cessation programs we commonly employ are utterly ineffective because they are based on outdated notions such as smokers being weak-willed.

Smoking, Pipe says, is not a habit or a lifestyle choice. It's an addiction, and: "We have to start offering evidence-based assistance for smoking cessation."

He helped develop the pioneering Ottawa Model for Smoking Cessation. The philosophy is simple: At every encounter with the health system, from a doctor's appointment to a hospital visit, a patient should be asked about smoking, they should be offered assistance in the form of pharmacotherapy and then follow-up counselling.

"Assistance with smoking cessation is a fundamental responsibility of every health-care practitioner," Pipe says.

Currently, when people are offered help, it is usually in vague terms, and using inadequate tools. Pipe says smoking cessation should be promoted as aggressively as blood-pressure control. When someone suffers from hypertension, they are not asked to consider getting their blood pressure down some day, they are prescribed medication, given a follow-up appointment and offered lifestyle counselling.

Smoking is much more deadly, but not taken as seriously.

There are essentially three first-line therapies to help people quit smoking: nicotine-replacement therapy, bupropion (brand name Zyban or Wellbutrin) and varenicline (brand name Champix or Chantix).

Nicotine is a powerful drug and if we want people to quit successfully, they need to be treated with equally powerful drugs.

While nicotine-replacement therapy (NRT) is used widely – it comes in gum, lozenges, patches, inhalers (e-cigarettes are not on the list because they are not approved for use in Canada) – it is used atrociously, Pipe says.

Patients usually get insufficient doses of nicotine and quickly return to smoking. Smokers have a remarkable ability to titrate their nicotine (to get exactly the amount that keeps them from suffering withdrawal) and they should be given that chance."NRT should be used in the dose and duration that is needed. Fixed doses are a Presbyterian approach," Pipe says.

The knock against the drugs, bupropion and varenicline, is that they have side effects. While that's true, they are generally minor and have to be measured against the benefits of quitting.

The way of the future will likely be combination therapy – using NRT and one of the medications – as is now the norm with blood-pressure control. But, above all, what is needed is a fundamental change in approach.

"Smokers don't need lectures or sermons, they need medical assistance," Pipe says. "We need to be clinicians, not moralists."

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