

# Virtual Mentor

American Medical Association Journal of Ethics  
November 2008, Volume 10, Number 11: 700-707.

## CLINICAL CASE

### **Balancing Health Promotion and Healing**

Commentary by Michael F. Roizen, MD, and Iyaad M. Hasan, MSN, CNP, and by David Clive, MD

Mr. Benjamin was a middle-aged construction worker with a history of hypertension and congestive heart failure who sustained a vertebral fracture in a job-related accident. He was admitted to Rockport Hospital's orthopedic surgery ward in unstable condition for treatment of his injuries.

To complicate matters, Mr. Benjamin was angry at having had his cigarettes taken away upon admission, as required under Rockport's smoke-free policy. The policy, part of a wide antismoking initiative, banned smoking on hospital grounds and within 50 feet of hospital property, eliminating even the possibility of walking outside for a cigarette break.

Mr. Benjamin was not doing well. He had smoked for more than 20 years and had no intention of stopping, despite counseling from his primary care physician. Though the hospital provided him with nicotine patches, he made it clear to the entire medical team including Dr. Thorman, the hospitalist in charge of his care, that he just wanted his cigarettes back. Over the course of 5 days, Mr. Benjamin grew extremely irritable and became short-tempered and uncooperative with the treating team. He threatened to leave the hospital against medical advice, refused to hold still for IVs or blood draws, and constantly tried to leave his hospital room despite being told to limit unnecessary movement.

Dr. Thorman realized that Mr. Benjamin's recovery would be greatly expedited if he were more compliant and wondered if Mr. Benjamin's outcome would improve if he were allowed to smoke during his stay. Dr. Thorman offered everything he could think of to help his patient relax—the nicotine patch, smoking-cessation therapy—all of which Mr. Benjamin refused.

Dr. Thorman knew that smoking was bad for his patient, particularly since he had heart disease, and that it was in direct violation of hospital rules. He recognized, however, the importance of speeding his patient's fracture recovery and allowing him to return to his family and work. Faced with this dilemma, he sought the assistance of the ethics consultant.

### **Commentary 1**

by Michael F. Roizen, MD, and Iyaad M. Hasan, MSN, CNP

Mr. Benjamin's situation raises ethical questions because of the effect cigarette smoke can have on the smoker and on bystanders exposed to second-hand smoke. The hospital policy banning smoking is similar to many societal regulations that restrict personal choice in the best interest of the individual and entire population. A comparable regulation is the law requiring individuals to obtain licenses to drive before entering public space behind the wheel of a motor vehicle—a regulation that must be followed in order to enjoy a privileged benefit. Mr. Benjamin's case invites us to consider:

- The effect of an individual's choice to smoke on his or her recovery from congestive heart failure, and the responsibility of the physician and society to hasten that recovery.
- The effect of an individual's choice to smoke on recovery time for orthopaedic injuries, and the responsibility of the physician and society to hasten that recovery.
- In-patient treatment of nicotine withdrawal where withdrawal symptoms may inhibit treatment of other conditions.
- Enforcement of hospital policies designed to protect the health of all patients and staff.
- Whether treatment for the primary acute injury can be delayed by a hospital policy.

We are not given specifics on how many cigarettes Mr. Benjamin smokes per day, but the extent of his withdrawal is not difficult to quantify. Enforcement of the hospital policy banned his cigarettes 5 days ago, and he is displaying physical signs of nicotine withdrawal [1]. Either physiologically or psychologically, he is suffering needlessly. The withdrawal symptoms can be treated with nicotine replacements, via patch, gum, or inhaler. It is the non-nicotine additives and particulates contained in inhaled tobacco products that are carcinogenic and inflammatory; in the short term, nicotine replacement could reduce Mr. Benjamin's symptoms, avoid harming him, and foster his recovery. Initiating replacement therapy is still a viable option if we can overcome Mr. Benjamin's initial resistance to it.

The first clinical ethics topic of concern is that Mr. Benjamin has congestive heart failure. Smoking accelerates the progression of coronary heart disease and diminishes the blood's capacity to carry oxygen to the body [2]. Smoking is also linked to congestive heart failure, and the number of diagnoses is elevated among smoking populations [3]. More smokers die from heart disease and plaque ruptures than cancer [2, 4, 5]. Even second-hand smoke increases incidences of acute coronary syndrome events [6]. Under no circumstances can a caregiver enhance the risk of an adverse condition unnecessarily. Dr. Thorman has not exhausted all of his options with regard to treating Mr. Benjamin.

The second clinical ethics concern is Mr. Benjamin's broken vertebrae from a work-related accident. The recommended rest and treatment is inhibited by his agitated state that is triggered by nicotine withdrawal. Most of the symptoms manifest between the third and fifth days of removal, and the majority of patients report that

symptoms begin to improve after the first week. While Dr. Thorman may consider allowing Mr. Benjamin to smoke in order to gain his adherence to treatment, bone-healing time takes longer in smokers than in non-smokers [7]. The net effect of allowing Mr. Benjamin to smoke may not speed his short- or long-term recovery.

Nicotine withdrawal symptoms include cravings, irritability, inability to concentrate, insomnia, and fatigue. With nicotine replacement agents in patch, lozenge, or inhaler form available, and, given the evidence that second-hand smoke is harmful to anyone exposed, Mr. Benjamin should be prohibited from smoking. Medications are available to help reduce the physical symptoms of withdrawal, but they may not be effective due to Mr. Benjamin's unwillingness to quit at this time. It might be useful to ask some ex-smokers to talk to Mr. Benjamin, people whose congestive heart failure symptoms improved after they quit smoking by using a nicotine-replacement agent. Candidates can be found at hospitals with smoking-cessation clinics, and those who have succeeded in giving up smoking often want to help others.

Making an exception to allow Mr. Benjamin to smoke in the hospital would set an extremely poor precedent. If his withdrawal symptoms and resistance to nicotine replacement therapies do not lessen with time, another option is allowing him to sign out against medical advice. A doctor can arrange a home visit from a nurse or other professional who has no ethical opposition to individuals smoking at home. We firmly believe that a doctor should not prescribe or agree to a treatment that poses a direct hazard to other patients.

The job of a medical professional is to help Mr. Benjamin through education and symptom control such as nicotine-replacement therapy. This strategy also reinforces the role of a doctor as a teacher. Even if it is possible to isolate the patient so that tobacco use does not affect others, and to provide staff willing to be exposed to second-hand smoke, the no-smoking policy is an example of regulations that put societal benefit above individual preference. Returning to the driving analogy, everyone needs a license to drive a motor vehicle in a public space. Is it reasonable, safe, or helpful to make exceptions to that regulation?

## References

1. Fielding JE, Husten CG, Eriksen MP. Tobacco: health effects and control. In: Maxcy KF, Rosenau MJ, Last JM, Wallace RB, Doebbling BN, eds. *Public Health and Preventive Medicine*. New York, NY: McGraw-Hill. 1998.
2. Centers for Disease Control and Prevention. Annual smoking-attributable mortality, years of potential life lost, and productivity losses—United States, 1997-2001. *MMWR*. 2005;54(25):625.
3. United States Public Health Service. Office of the Surgeon General. The health consequences of smoking: nicotine addiction: a report of the surgeon general. 1998. <http://profiles.nlm.nih.gov/NN/B/B/Z/D/>. Accessed August 25, 2008.

4. Centers for Disease Control and Prevention. 2001 surgeon general's report—women and smoking. 2001.  
[http://www.cdc.gov/tobacco/sgr/sgr\\_forwomen/index.htm](http://www.cdc.gov/tobacco/sgr/sgr_forwomen/index.htm). Accessed August 25, 2008.
5. United States Public Health Service. Office of the Surgeon General. Reducing the health consequences of smoking: 25 years of progress: a report of the surgeon general: 1989 executive summary.  
<http://profiles.nlm.nih.gov/NN/B/B/X/S/>. Accessed August 25, 2008.
6. Pell JP, Haw S, Cobbe S, et al. Smoke-free legislation and hospitalizations for acute coronary syndrome. *N Engl J Med*. 2008;359(5):482-491.
7. Centers for Disease Control and Prevention. 2004 surgeon general's report: the health consequences of smoking. 2004.  
[http://www.cdc.gov/tobacco/data\\_statistics/sgr/sgr\\_2004/index.htm](http://www.cdc.gov/tobacco/data_statistics/sgr/sgr_2004/index.htm). Accessed August 25, 2008.

Michael F. Roizen, MD, is chief wellness officer and chairman of the Wellness Institute at Cleveland Clinic in Ohio. He is a past chair of a Food and Drug Administration advisory committee. He is interested in defining lifestyle changes that allow people to lead healthy, younger-feeling lives.

Iyaad M. Hasan, MSN, CNP, is a nurse-practitioner who specializes in pediatric and adult tobacco treatment. Mr. Hasan is a director of the Tobacco Treatment Center at Cleveland Clinic in Ohio.

### **Disclosure**

Dr. Roizen serves as chair of the advisory board of RealAge, Inc., a web-based supplier of health information that depends on advertising revenue. RealAge clients include all 18 major pharmaceutical firms, including those that produce nicotine-replacement and other anti-craving or cigarette-cessation products. Dr. Roizen developed and sold rights to a drug that is being commercialized by a pharmaceutical firm that sells a nicotine-replacement product.

### **Commentary 2**

by David Clive, MD

Like most clinical ethics problems, this one is a dense, multilayered composite of many questions. In seeking a resolution, it is useful to begin by defining each of the component questions and examining its relative importance. Some may prove irrelevant or trivial and can be eliminated from consideration along the way. Others may require the assistance of additional resources (the patient's orthopedist, internist, nurse, consulting psychiatrist, and the patient himself). With luck, the answers to key questions can be melded into a practicable solution. Following this algorithm allows us to (1) identify the fundamental issue; (2) examine it in the full context of the case, and (3) formulate a resolution that most comprehensively addresses the issue and its ramifications. Let's see how this process plays out in the case of Mr. Benjamin.

### **Medical Questions**

1. How serious are the patient's injuries? How much of a risk is it to the patient if he is allowed to leave without further treatment?

The treating team states that his spine is not stable enough for him to terminate treatment. We can infer from the team's concern that this is a serious safety issue.

2. What is the patient's overall state of health? What is the basis for his congestive heart failure? Would either his new or underlying medical problems be exacerbated by allowing him to smoke?

We do not have all of this information and may need to talk with his primary caregiver. As a general rule of thumb, however, smoking does not acutely exacerbate heart disease or impair bone health. Chronically, it does both, and future efforts should continue to stop Mr. Benjamin's tobacco use. For now, it seems unlikely that a strong medical argument can be marshaled against letting him smoke in the hospital. We could argue that we are justified in permitting him to smoke under the ethical principle of "double effect," which holds that the physician is justified in pursuing a management course that may lead to an unintended consequence if the likelihood of achieving the intended benefit is high.

### **Psychosocial Questions**

1. Why are cigarettes such a highly charged issue for Mr. Benjamin? Is he addicted to nicotine or does the right to smoke really represent a control issue for a relatively young, active man who suddenly finds himself in a position of helplessness?

2. Is he making a rational, authentic decision, or are his thought processes clouded by delirium, depression, or anxiety?

These two psychosocial questions demand due diligence. Interview the patient, but be prepared for an irritable response to any questions as to why he's so angry or upset about being denied cigarettes. Ascertain that he understands the consequences of refusing treatment. Make certain he is not suffering from some medication-related or metabolic derangement that is adversely affecting his sensorium. Ask his nurse and anyone familiar with him if his behavior has changed markedly and whether he is manifesting confusion or signs of depression. Request a psychiatric consultant, if necessary. For the sake of discussion, let's assume that you have eliminated delirium or a primary psychological cause for Mr. Benjamin's anger. He is simply an irritable, nicotine-addicted adult taking a rational—if unproductive—position.

3. If he were to leave the hospital, could he receive necessary care in an alternate environment wherein he would be allowed to smoke?

Many hospitals are adopting strict tobacco-free policies, which may make it difficult to find adequate, acute care for his vertebral fracture in a setting that tolerates

smoking. If the patient is a veteran, a Veterans Administration hospital may offer such a solution, although even the traditionally smoke-laden Veteran's Administration hospitals have joined the smoke-free movement. Depending on his resources, he may be able to receive comprehensive care at home; you will need to ask his social-service case worker and orthopedist if this is feasible from the financial and medical perspectives, respectively.

### **Policy and Legal Questions**

1. Is the hospital's antismoking policy ever waived in extraordinary circumstances?

Antismoking policies are generally inflexible. If exceptions were tolerated, enforcement of the policy would become almost impossible. A valid argument can be made that smoking anywhere on the premises compromises the health and safety of others. This is a critical point. To be sure, we allow narcotic-addicted patients to receive methadone while hospitalized to satisfy their cravings, but one patient's use of methadone has no adverse effect on anyone else on the premises. We can assume that a settlement allowing Mr. Benjamin both to smoke and remain in this hospital is not an option here.

2. What is the hospital's liability if he is discharged prematurely, even at his own instigation?

If this patient were to suffer injury or death as a result of his refusal of treatment or leaving against medical advice, the hospital and physicians should not be held liable. In fact, however, there is no way to prevent him from suing. It is critical to document exactly what the patient has been told about his condition, his need for ongoing inpatient care, and the potential consequences of his refusal. The hospital's risk-management and legal officers must be alerted preemptively.

3. Are there grounds for holding and treating him against his will, without cigarettes, in the hospital on the presumption that his position, "either I smoke or I refuse treatment," is self-destructive?

Definitely not. Mr. Benjamin has the capacity to make his own decisions and is entitled, under the principle of respect for autonomy, to have them honored.

### **Working toward Resolution**

We can now winnow out those questions, namely the last two, that are not immediately relevant to any advice we will offer as ethics consultants. Adequate attempts to educate and negotiate with the patient have been made and documented in the medical record. And the central issue has been identified: this rational, autonomous patient is adamant about continuing to smoke through his hospitalization—one that is necessary for his health and safety—yet the hospital will not permit him to smoke under any circumstances.

When a conflict seems irresolvable—as this one does—negotiation comes into play. The ethics consultant can serve as a mediator between the treating team and patient and may even develop conditions to be “put on the table.” Most hospitals also have patient advocates or representatives who can assist in negotiating terms of care with patients. Here are some possible concessions to offer Mr. Benjamin: (1) shorten his inpatient treatment as much as possible under the circumstances if he’ll bear with you a little longer, (2) suggest appropriate medications to take the edge off his cigarette cravings (benzodiazepines, bupropion, nicotine supplements, etc.), and (3) ask if there is anything you can do to help him through this difficult period.

Presenting Mr. Benjamin a time frame for discharge and treating him with respect may lead to common ground. It would be glib to argue that any of the above strategies is likely to work. Still, they must be tried. Everyone loses if Mr. Benjamin doesn’t get the treatment he needs. The prospect of transfer to an institution that permits smoking or to his home with home health care are last resorts.

The trend toward making hospitals smoke-free is two decades old and spreading rapidly. In spite of this, almost nothing has been written about the implications of patients refusing to comply with smoke-free rules. We can anticipate broader questions ahead. How will we handle such cases if all hospitals become smoke-free? Will we need smokers’ and nonsmokers’ hospitals or hospital wards? What other self-destructive behaviors will physicians have to use as bargaining chips in negotiating care plans with patients?

### **Suggested Readings**

Bronaugh TA, Frances RJ. Establishing a smoke-free inpatient unit: is it feasible? *Hosp Community Psychiatry*. 1990;41(12):1303-1305.

Fiore MC, Jorenby DE. Smoke-free hospitals. A time for universal action. *Chest*. 1992;102(5):1317-1318.

Philpot TK. The ethics of smoke-free zones: an exploration of the implications and effectiveness of a non-smoking policy as a health-promotion strategy in the context of an orthopedic trauma ward. *J Clin Nurs*. 1994;3(5):307–311.

David Clive, MD, is a nephrologist and professor of medicine at the University of Massachusetts Medical Center in Worcester, where he chaired the ethics committee for many years. He has won numerous teaching awards and the 2007 Leonard Tow Humanism in Medicine Award from the Arnold P. Gold Foundation.

### **Related in VM**

[Practicing Preventive Medicine through Preventive Employment Practices](#), November 2008

[The Ethics of Requiring Employees to Quit Smoking](#), January 2007

[Managing Prehypertension](#), November 2008

*The people and events in this case are fictional. Resemblance to real events or to names of people, living or dead, is entirely coincidental.*

*The viewpoints expressed on this site are those of the authors and do not necessarily reflect the views and policies of the AMA.*

Copyright 2008 American Medical Association. All rights reserved.