Statement on Smoking Prevention

Student National Medical Association
Health Policy and Legislative Affairs Committee
Statement on Smoking Prevention

Fourth Revision

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INTRODUCTION

Tobacco use has a checkered history in the United States. The *Nicotiana* genus is indigenous to the Americas and was cultivated by the continent’s first people for centuries before colonization. After being introduced to European settlers by the local population, smoked tobacco became a staple of the burgeoning agrarian south and has since ballooned into a massive industry. We have also become painfully aware of the dangers of exposure to cigarette smoke. The Center for Disease Control and Prevention (CDC) attributes about 480,000 of the nation’s annual deaths to cigarette smoking, with about 41,000 of those being attributable to secondhand-smoke. Indeed, tobacco use is the single largest preventable cause of death and disease in the United States.

Tobacco Use Disorder is listed in the Diagnostic Statistics Manual V and should be approached with the same sensitivity as any other physical or psychiatric condition. It has been found that among those who experiment with cigarettes, 20-30% will eventually meet the criteria for tobacco use disorder in their lifetimes. Physicians must provide accurate and comprehensive counsel to their patients regarding tobacco use. It is for this reason that the SNMA believes it is crucial to track, evaluate and participate in public health efforts towards comprehending and curbing tobacco use, especially among vulnerable populations.

The purpose of this statement is to review the most recent literature regarding tobacco trends, safety and legislation. This statement will also put forth recommendations for all SNMA affiliated and non-affiliated physicians on decreasing the harm done to public health by tobacco products.

BACKGROUND

Tobacco use is associated with a host of familiar long-term health risks. These include cancer of the larynx, pharynx, oral cavity, esophagus, uterine cervix, pancreas, bladder, and kidney when consumed via inhalation or chewing. Smoking is also a major cause of coronary heart disease (CHD), being responsible for almost a quarter of deaths due to CHD. The Surgeon General has also documented that smoking increases the risk of cerebrovascular disease, chronic obstructive pulmonary disease (including emphysema), and developmental delays in utero. Smokeless tobacco, in particular, is associated with halitosis, periodontal degeneration, soft tissue lesions, and oral cancer.
Children and young adults are at particularly high risk for long-term disease due to tobacco use. Cigarette smoking in adolescence appears to arrest lung development and limit the level of maximum lung function that can be achieved. Young smokers are less likely to be physically fit than nonsmokers and more often complain of coughing spells, shortness of breath, wheezing, and phlegm production. While tobacco use amongst adolescents had been steadily declining, the rise in popularity of electronic nicotine delivery systems (ENDS) has resulted in a recent uptick in tobacco use amongst middle and high-school aged youth.

The rate of tobacco use in the United States has steadily been declining since the mid-20th century. In 1965, 42.4% of US adults claimed to be smokers. By 2016, that number was less than 16%. However, the decline has not been equally robust across the nation. The U.S. News & World Report identified that individuals (1) living below the poverty line, (2) living without health insurance, (3) designated as American Indian/Alaska Native (AI/AN), (4) identifying as multiracial, and (5) without a high school degree had significantly higher incidences of tobacco use as compared to the general population.

Encouragingly, many pieces of legislation at all levels of government intended to curb smoking rates were passed in 2017. Five states - California, Hawaii, Oregon, New Jersey and Maine - raised the legal age for the purchase of tobacco products from 18 to 21. This move is clearly intended to prevent tobacco use in adolescents, which is crucial considering the risk for dependencies developed during this period to become lifelong addictions. Kentucky and South Carolina both expanded Medicaid coverage to include programs which help people quit smoking - a strategy that will significantly benefit individuals at risk of tobacco use due to their income status. Louisiana and Texas passed smoke-free laws intended to address the public health risks of secondhand smoke. Indiana, North Carolina and Tennessee all increased spending for prevention programs by over $1 million. However, funding for prevention decreased in both West Virginia and Texas. Connecticut, Delaware, Rhode Island and New York all increased cigarette taxes, but this type of regressive tax strategy has been criticized for decreasing tobacco use amongst children, young adults and low-income individuals while doing little to affect the habits of other high-risk groups. Instead, these taxes result in an increased financial burden disproportionately carried by individuals whose root cause of addiction is not being adequately addressed.

It is too soon to evaluate the effects that increases in legal purchasing age, which have only begun to go into effect, will have on prevalence of adult smokers in the US. However, evidence
suggests that the most popular legislation passed with the goal of decreasing the harm done by tobacco products, such as raising the purchase age and increasing cigarette taxes, has little effect on lowering rates of tobacco use in populations most vulnerable to nicotine addiction.

**SCOPE OF THE PROBLEM**

Traditional public health campaigns against tobacco use have been geared towards exposing the health risks and limiting tobacco advertising, and they have been relatively successful at this goal. As of 2008, 96% of US Americans believed that smoking cigarettes was at least somewhat harmful. In 2009, President Barack Obama signed the Family Smoking Prevention and Tobacco Control Act which limited audio-visual advertising (e.g., at point of purchase), except in adult-only facilities, to black text on white background visuals and spoken words (no music, images or moving images) and banned outdoor advertising within 1,000 feet of schools and playgrounds, among other restrictions. As a result, US Americans are seeing less tobacco advertising than ever before. As of 2016, approximately 15.5 out of every 100 US Americans smoked cigarettes.

However, there are some populations that are using tobacco at significantly higher rates than the national average, despite having knowledge of the health risks and limited access to tobacco advertisements. Since cigarette smoking is an indication of a tobacco use disorder, we will expect those populations at higher risk for cigarette smoking to be similar, in some ways, to those at risk for other substance use disorders. Here, we will dig deeper into some of those populations identified in the literature, in an effort to make targeted recommendations for treating patients who belong to them.

People at risk of developing tobacco use disorder include those who are: 2, 4, 10, 13, 15–19

**Living in Poverty**

Those living at or below the poverty line are 1.8 times as likely to smoke cigarettes than those who do not. Chronic financial strain and extreme resource limitations are risk factors for substance use disorders. Physicians should be prepared to direct their low-income patients to services that provide food, shelter, healthcare and other material support at little to no cost. Additionally, regressive taxes may compound the financial stress of people whose nicotine addiction is driven by poor economic conditions and this effect must be considered when such legislation is being evaluated.
American Indian/Alaska Native

The tobacco plant was cultivated and utilized by humans in the Americas for at least one thousand years prior to the arrival of colonial explorers in the 15th and 16th centuries. Many indigenous folks still cultivate and use their own tobacco, but a great number have taken up smoking in the form of commercial cigarettes. Among those individuals who are federally recognized as American Indian or Alaska Native, the rate of cigarette smoking is over twice that of the general population. In 2018, it was reported that members of the White Earth Nation were working towards lowering the rate of cigarette smoking amongst their tribe by reviving the practice of growing their tobacco and smoking it only during sacred rituals, in the tradition of their pre-colonial ancestors. Research should be conducted on the feasibility of this effort as a potential harm-reduction strategy that is sensitive to the ancient relationship many members of the AI/AN community have with the tobacco plant.

Arab Americans

Arab Americans smoke cigarettes at a rate between 2.5 and 4.5 times that of the general population. One contributor to this difference that has been identified is the longstanding cultural norm of social smoking in many Western Asian communities. This tradition is attributable to the popularization of the nargile (hookah) in the Ottoman Empire during the 17th century. While data regarding the long-term health risks of nargile versus cigarette smoking is still emerging, physicians should be sensitive to the way they discuss smoking cessation with individuals who link tobacco use to any part of their identity.

Lesbian, Gay or Bisexual Americans

Individuals who identify as lesbian, gay or bisexual are 1.3 times as likely to smoke as those who identify as heterosexual. Rejection or discrimination based on sexual orientation at home, school or work likely contribute to this prevalence. Patients should be asked about their sexual orientation and about the attitudes of their family, friends and peers regarding their identity. Physicians should also be prepared to direct LGB patients to resources that can help them find community and support.
**Transgender Americans**

Transgender persons face a number of daily challenges related to the institutionalization of a fallacious gender binary. These can include housing and employment discrimination, social pressure to ‘pass’ as one binary gender or the other, administrative challenges associated with name or gender marker changes and rejection or isolation from family and friends. As a result, transgender people are 1.8 times more likely to smoke cigarettes than their cisgender peers as well as being at increased risk for other psychiatric conditions. Physicians should ensure that their transgender patients feel affirmed and supported in their self-identified gender by those who surround them and refer these patients to support groups or counseling, as they desire.

**Active or Retired Military Personnel**

Active duty military personnel are 1.3 times as likely to smoke cigarettes as civilians and male veterans are 1.2 times as likely to smoke cigarettes as nonveterans. Ameliorating the stresses of serving or having served in the United States military may not be possible in clinic. However, campaigns targeted toward the culture of tobacco use within the military, led by high-ranking servicemembers and endorsed by physicians, may be effective in lowering the rates of smoking amongst individuals in or retired from the military.

**HIV+ Americans**

Although HIV is now a quite manageable infection, deep social stigma and the need for frequent interaction with the medical system both contribute to high rates of depression and anxiety amongst HIV+ individuals. Additionally, HIV contributes to neuronal disease and cognitive decline as the disease progresses - an effect which is also associated with depression. These factors likely contribute to a smoking rate amongst HIV+ individuals that is two times that of HIV-individuals. HIV+ patients should be asked about their attitudes regarding their illness and referred to support groups or counseling to assist with coping as indicated.

**Adults with Mental Health Conditions**

Adults who reported having a diagnosed mental health condition (not including a developmental disability or substance use disorder) are 1.7 times more likely to smoke cigarettes than those who do not. These adults face higher rates of ostracization from their family, friends
and peers. In addition, many mental health conditions can make it difficult for patients to work or complete daily activities. Most individuals with mental health conditions are not adequately treated, with only 40% receiving mental health services within the past year. Individuals with diagnosed mental health conditions should be screened for substance use disorder and should have regular appointments with a physician to ensure their illness is being managed appropriately.

**Adults with Disabilities**

Adults who reported having disabilities or limitations are about 1.5 times more likely to smoke cigarettes than those who did not. Physical disabilities which limit an individual’s mobility or preclude them from taking part in standard daily activities may make an individual more likely to partake in negative health behaviors such as smoking cigarettes or watching TV. This might be due to the physical barriers associated with performing such activities (e.g. building accessibility, transportation, etc.) or anxiety/depression created by the social barriers of repeatedly having to request that one’s disability be accommodated. Adults with disabilities should be asked about both their ability and desire to access things that bring them joy, such as hobbies or friends and family.

**Adolescents**

Fortunately, minors smoke cigarettes at a rate significantly lower than the general population. (Albeit, the fact that there is a cigarette smoking rate amongst middle and high school-aged youth is itself concerning.) Amongst 10th- and 12th-grade students, 6.3% and 11.4% reported cigarette use in the past month, respectively. However, there is a lurking statistic amongst this demographic that the typical inquiry: “Do you smoke cigarettes?” is not likely to catch. The proportions of students from the same group who had tried some type of ENDS (e.g. e-cigarette, e-hookah, vape pen) were 14% and 16.2%, respectively, with the latter number edging out the smoking rate amongst the general population. The proportion of high school students using ENDS tripled between 2013 and 2014, and the trend has shown no signs of slowing down.

Electronic cigarettes have been proven to contain less of the toxic chemicals contained in standard cigarettes. However, in addition to posing health risks to the user, e-cigarettes (especially those with features widely considered to be appealing to young consumers, such as flavored smoke) have the potential to lead to nicotine addiction and subsequent cigarette smoking early on in life. Young adults should be interviewed about tobacco use without a parent present as
part of their annual physicals. During the standard HEADSS assessment, both cigarettes and e-cigarettes (or ‘vape’) should be inquired about and the most accurate counsel available should be given to the patient. Additionally, a longer interview or a referral to family counseling might enable the patient to address the external forces driving the tobacco use. Particular sensitivity is needed when addressing patients at this transitional, and often challenging, period of their lives.

**STATEMENT OF POSITION AND RECOMMENDATIONS**

The Student National Medical Association (SNMA), founded in 1964 for the benefit of underrepresented minority medical students and underserved patient communities, affirms the reality that tobacco-related pathology remains the most preventable disease burden in the United States. It is the opinion of the authors of this document that substantial improvement has been made, but there remains work to be done.

Eighty-five percent of US American adults do not currently smoke. Of current smokers, 7 out of 10 report that they would like to quit smoking.\(^{21}\) The SNMA makes the following recommendations to practicing physicians and healthcare providing institutions in an effort to ensure those numbers continue to increase.

1. Utilize supported methods such as motivational interviewing to counsel patients on smoking cessation.\(^{22}\)
2. Develop interviewing methods that are sensitive to cultural relationships to tobacco.
3. Practice discussing tobacco use with adolescents in a sensitive, informed, and supportive manner.
4. Educate yourself about the resources and support groups available to at risk populations in your area.
5. Refer interested patients with potential tobacco use disorder to counseling for further psychological evaluation.
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