Text and Context

The Question that I Could Not Answer

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My journey to a research career began when a patient asked me a question that I could not answer. One busy night long ago, as an intern working overnight in the intensive care unit, I took a call from a clinic patient. She told me that she was pregnant, that she smoked and that she knew that she should stop. Could I help her?

The answer was simple. No, I could not.

What I had learned about tobacco in medical school in the late 1970s was limited to this: smoking is bad, quitting is good, and never starting is even better. It had never occurred to me that part of a doctor's job is to help patients change the behaviors that harm their health. In my training I had absorbed the prevailing attitude that doctors had more important things to do. I thought that the extent of my job as a physician was to educate a patient about what behaviors were harmful. It was the patient's job to take my advice, use will power, and change his or her bad habits.

It didn't take long for me to see the limits of this approach. As my residency progressed, I spent long hours caring for people who died far too young of tobacco-related diseases. I learned how to diagnose and treat these diseases, and I tried to relieve my patients' suffering. But rarely could I change the relentless downward course of my patients' illnesses. Their premature deaths were tragedies with repercussions far beyond one individual.

I vividly recall one of my favorite clinic patients, a very stylish middle-aged African American woman who smoked. At our visits, I addressed her diabetes and hypertension, did her breast exams and Pap smears, and chatted about her family. Gradually I came to understand that she was the glue who held together a struggling family. Then, an X-ray done for some reason revealed a lung nodule, and we diagnosed her lung cancer. I cared for her through this terminal illness. On her deathbed, one son was brought from prison in shackles and chains to say goodbye to his mother. It was an image I will never forget. He was later paroled, but the loss of her firm guidance was irreplaceable.

Reflecting on these and other patients, I wondered why we couldn't move health care upstream. Why couldn't physicians try to prevent these diseases by addressing unhealthy behaviors like tobacco use directly? How could physicians and health care systems help smokers to quit? These are the questions that I've tried to answer ever since.

The answer was far more complex than I expected. First, we lacked a full understanding of the problem. In 1964, when the US Surgeon General's Report first identified tobacco use as a cause of lung cancer, cigarette smoking was considered to be just a bad habit (or even just a "choice," as the tobacco industry would have had us believe). Large numbers of smokers quit after learning about the health risks of cigarette smoking, but many more did not.

By the 1970s, the tenacity of smoking behavior was recognized, prompting the emergence of psychological counseling strategies to help smokers quit. In the 1980s, the role of nicotine as an addictive drug was finally recognized as critical to sustaining smoking. Soon after, nicotine replacement medications to help smokers quit by blunting the symptoms of nicotine withdrawal appeared. Having a biological rationale, and, even better, drugs to prescribe, "medicalized" tobacco use and helped to stir physicians' interest in considering it their business to treat tobacco use. Even back then, however, physicians had so many competing demands on their time that addressing tobacco use remained a low priority for most. It has taken decades for the idea that addressing tobacco use is an essential part of being a good doctor to take root. Indeed, this is still a challenge today, especially in specialties outside primary care.

We now understand tobacco use to be a complex behavior maintained by a web of physiological, psychological, and socio-cultural forces. We consider it to be a chronic disease, an insight that has stimulated new approaches to treatment. We apply the tools developed to manage other chronic diseases to addressing tobacco use, and we seek to leverage teachable moments in a smoker's life, such as a hospitalization or the new diagnosis of serious disease, to encourage permanent behavior change. Sometimes what seems like a great idea proves to be an effective strategy; at other times, it disappoints us but the evaluation leads to new insights and with luck hypotheses to test. For me, the enduring appeal of research is the opportunity to answer a question that I define, that I care deeply about, and whose answer can improve my patients' health.

Choosing this path had its challenges. When I began, addressing tobacco use was regarded as a fringe research topic in a department of medicine. Over time, I have been pleased to watch the topic move gradually toward the mainstream. Now, I see many of my colleagues working to help patients alter a

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wide range of health-related behaviors. Increasingly, clinicians and researchers are venturing even further beyond traditional boundaries to address the social, economic, and psychological forces that cause or worsen chronic diseases like tobacco addiction. In doing so, we are expanding the scope of what it means to be a healer, and we are reshaping the systems in which we care for our patients.

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