Can Physicians Refuse Treatment to Patients Who Smoke?

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Introduction

According to the Hippocratic tradition, the guiding principle for physicians is "first do no harm," or nonmaleficence, which is closely followed by the obligation to "do good," or beneficence.[1] In Western medicine, much of medical ethics has been dominated by respect for individual patient autonomy. In their interactions with patients, physicians often go to great lengths to provide detailed information about the risks and benefits of medical treatments so that patients can make independent medical decisions consistent with their personal values and beliefs.[2]

Enabling patients is particularly challenging when patients engage in behaviors or activities that are harmful to their health. Physicians and others may form negative judgments about these patients or suggest that they deserve fewer health care resources when such resources are scarce. Some have argued that cancer-related treatment may be refused to active smokers because smoking is an autonomous risk-taking behavior that is anathema to a comprehensive curative therapeutic approach. However, irrespective of the "rightness" of smoking behavior, physicians have a duty to offer all patients appropriate anticancer therapy and supportive care and to help their patients become tobacco free.

Case Study

A man 56 years of age presents with a 6-month period of weight loss, lethargy, cough, and right costal margin pain. When giving his medical history, the patient discloses that he has smoked one pack of cigarettes per day for 40 years. The patient's medical history includes a myocardial infarct, severe chronic obstructive pulmonary disease, and peripheral vascular disease. The patient is diagnosed with non–small-cell lung cancer with synchronous hepatic metastases and is referred to a medical oncologist to discuss his treatment options. The oncologist outlines the likely benefits of chemotherapy but expresses a strong reluctance to treat the patient if he continues to smoke. In refusing to treat the patient, the oncologist voices an objection to treating patients who will not stop engaging in the very activity that most likely caused their disease. In addition, she cites possible treatment complications resulting from the comorbidities associated with long-term tobacco use.

Smoking and Refusal of Treatment

Although professional ethics permit physicians to refuse to deliver nonemergent treatment if it conflicts with their personal, religious, or moral beliefs, this type of conscientious objection is usually reserved for controversial circumstances, such as the decision to perform an abortion or to withhold or withdraw life-sustaining treatment.[3,4] Physicians are discouraged from refusing treatment simply because they disagree with their patients' decisions or lifestyles.[5]

The authors contend that active smoking is not an appropriate basis for refusal of therapeutic treatment. Rather, oncologists and other physicians who maintain relationships with patients who smoke are in a unique position to help these patients reduce their dependence on tobacco. As noted in ASCO's recently published policy statement on the role of oncologists in cancer prevention and risk assessment,[6] oncologists can provide patients who smoke with information about nicotine addiction and the link between smoking and cancer. Oncologists can also direct patients to appropriate support networks that address smoking cessation and to clinical interventions and pharmacotherapeutic cessation treatments, where appropriate. Most importantly, oncologists can use their regular contact with patients to consistently reinforce the importance of smoking cessation and to make sure patients have access to smoking cessation treatments that meet their individual needs.

Helping patients stop smoking is more consistent with physicians' affirmative duty to act in the best interest of patients than refusal of treatment. Furthermore, refusal to treat patients who smoke could have the harmful effect of delaying time-sensitive treatment while patients connect with new physicians. In addition, refusal to treat patients who smoke could have a detrimental impact on communication between physicians and patients, who might not provide complete information about their medical histories if it could be used against them.

Accounting for Smoking-Related Comorbidities and Risks

It is known that smoking-related comorbidities can make cancer treatment less effective, increase a patient's risk of complications related to treatment, and increase a patient's risk of development of other primary cancers.[6] It is appropriate for physicians to take the comorbidities of smoking into account when determining how best to treat patients who smoke. For example, a patient who smokes and has chronic obstructive pulmonary disease and cardiovascular disease may not be an appropriate candidate for surgery or for certain chemotherapeutic regimens with known cardiac and pulmonary risks. Even if initial treatment is successful,

continued smoking could make therapy less effective and increase risk of relapse. When a traditional risk-benefit analysis rules out standard treatments, the physician should continue to treat the patient in an appropriate manner, including by providing supportive care.

Smoking and Allocation of Health Care Resources

In light of the finite nature of health care resources, it has been argued that physicians should prioritize the treatment of nonsmoking patients over patients who smoke.[7] However, this argument—that it is preferable to devote finite health care resources to treating patients who do not choose to engage in risk-taking and self-destructive behaviors—is difficult to sustain. Most patients engage in some behaviors that contribute to poor health. A physician who refuses care to smokers on this basis might, by logical extension, be compelled to refuse to treat patients who have other risky habits, such as consuming fatty foods, alcohol, or excessive sugar or failing to exercise.[8] Ultimately, these judgments about risk-taking behaviors are not supported by morally or practically relevant distinctions.[9,10] Although physicians are expected to be good stewards of scarce medical resources,[11] allocation decisions should be made on the basis of the costs, benefits, effectiveness, and possible futility of treatments, not on assignment of blame.

One area to which it is inarguably important to devote health care resources is smoking cessation. Promoting a tobacco-free lifestyle is essential to preventing the need for costly cancer treatments. In addition, as the number of survivors of cancer continues to increase, it is important to stress that smoking cessation is critical to maintaining good health and lowering the risk of recurrences and secondary cancers. Although surveys show most oncologists discuss smoking cessation with their patients, physicians may not be aware that counseling patients about smoking cessation is reimbursable under Medicare.[6]

Conclusion

In applying these arguments to the case study, it becomes clear that the oncologist cannot ethically refuse to treat the patient because he smokes. Rather, the oncologist should provide the patient with appropriate treatment that accounts for the patient's smoking-related comorbidities and includes an appropriate complement of supportive care. Furthermore, the oncologist should take advantage of every opportunity to discuss with the patient the importance of smoking cessation and help the patient access appropriate smoking-cessation resources.

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