Tobacco and health care

The CMA Policy Summary "Tobacco and health" (*Can Med Assoc J* 1997;156:240A-C) is a welcome statement supporting the activity of many physicians across the country who are trying to work, in their practices and in the community, to develop a smoke-free society.

Although the statement is a helpful start, I feel that it has 2 glaring omissions. The first deals with physicians' overall concern for the health of their patients. To date, in BC and most other provinces, physicians are prohibited from billing the medical services plan or patients directly for counselling advice to help a patient to become a nonsmoker. We are expected to provide better health care with ever-decreasing dollars, yet we are often criticized for not being more active advocates of disease prevention. Failing to point out this deceitful paradox is a serious lack.

The second issue is one of regulation. It is known and proven that tobacco is an addictive and hazardous product. Therefore, even though our current government feels that it cannot legislate a complete ban of cigarette sales, it is unethical to allow Canada to export a potentially lethal substance to other countries. A very strong statement should be included in the CMA statement that the Canadian government should implement a policy to prohibit any sales or exports from Canada to other countries. An equally strong statement should be made to prohibit importation of any tobacco products into Canada.

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As a psychiatrist/addictionist, I find it distressing that the most intense opposition to smoking bans and to the treatment of nicotine dependence seems to be found in addiction-treatment facilities and psychiatric hospitals.

There is no scientific justification for this resistance.[1] According to Dr. Richard Hurt, smoking-related illness is by far the leading cause of death in recovering alcoholics; and it is presumably the foremost cause of death among other addicts and patients receiving psychiatric care as well.

According to Dr. Terry Rustin, in US treatment centres addicts who give up tobacco at the outset of treatment complete treatment at higher rates and have improved and longer periods without relapse after treatment. The prelimary results seem so promising that it is difficult to justify to third-party payers that nicotine dependence not be treated concurrently with other addictions.

Fears that patients receiving psychiatric care will experience a relapse of depression upon smoking cessation may be exaggerated.[2,3] In fact, smoking tobacco significantly alters the P-450 enzyme system, necessitating higher doses of antidepressants and tranquillizers. Patients with psychiatric problems who stop smoking may need to be monitored for side effects and to have dosages lowered appropriately. For those who exhibit depression after smoking cessation, adequate antidepressant therapy and smoking-cessation support are the treatment of choice, not physician-approved tobacco use.

Many patients start smoking during stays at addiction and psychiatric treatment facilities. Those who smoke before admission tend to increase the amount they smoke during stays. Tobacco addiction, denial, rationalization and apathy about nicotine dependence are endemic among treatment staff.

Why were patients with other addictions (alcohol, marijuana, cocaine, amphetamines, opiates or prescription drugs), and psychiatric inpatients — populations with an 80% or more prevalence of nicotine dependence — not included as high-risk populations in the CMA policy summary on tobacco and health? These are glaring and unfortunate exclusions.

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References

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2. Practice guidelines for the treatment of patients with nicotine dependence. *Am J Psychiatry* 1996;153(4 suppl).
3. Dalack GW, Glassman AH. A clinical approach to help psychiatric patients with smoking cessation. *Psychiatr Q* 1992;63(1): 27-39.

[A member of the CMA Council on Health Care and Promotion responds:]

Both of Dr. Arkinstall's concerns have been addressed to an extent in the policy statement. The CMA is well aware of the issue of reimbursement for smoking-cessation counselling and other preventive services. An article in the same issue of *CMAJ* in which the policy appears includes a table of billing codes that could be used for clinical tobacco intervention (CTI) in each province and territory. CMA recognizes the need for reimbursement models to recognize the preventive health services provided by physicians. CMA's tobacco policy recommends that CTI be recognized as an essential part of health care and as a core medical service (i.e., one covered by provincial and territorial health insurance plans). The policy

also deplores the domestic manufacture of tobacco products for export.

Dr. Finlayson's letter touches on an interesting issue in clinical practice. CMA recommends that tobacco-intervention programs be created specifically for populations at risk; this recommendation would cover all populations, not just the ones mentioned by name in the policy summary. We certainly acknowledge that patients receiving psychiatric care and people with addictions are populations at risk (and, in fact, many also belong to other at-risk populations), although policy-makers such as governments do not tend to consider them a high-priority group. However, as Finlayson points out, there is disagreement within the profession as to the appropriate method of dealing with tobacco use among patients receiving psychiatric care and people with addictions. Finlayson's letter contributes valuable evidence to the debate, and we welcome his input. We will follow this issue with interest in coming years.

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Can we finally change the system?

I am forced to comment on the articles "What are the facts concerning the number of residency positions in Canada?" (*Can Med Assoc J* 1997;156: 665-7), by Dr. Dale Dauphinee and Dianne Thurber, and "Little room for error in Canada's postgraduate training system" (*Can Med Assoc J* 1997; 156:682-4), by Sandy Robertson.

I am one of the "lucky ones" who was able to find a residency in the specialty of my choice after first serving as a general practitioner in an underserviced part of Ontario for 5 years. I am now in my third year at the Medical College of Wisconsin in Milwaukee.

I commend *CMAJ* for publishing these 2 articles and for drawing some attention to this topic. However, I am hurt by Dr. John Hoey's comments in the Editor's preface, which imply that things are not as bad as they seem. If he is having trouble understanding this issue, then I assume others are having the same problem.

In their article, Dauphinee and Thurber fail to mention the number of first-year residency positions. I would like to know how the "re-entry trainees (Canadian graduates)" positions are defined. They give figures of 632 in 1993 and 489 in 1994. When I applied in those years, there were none. Finally, I find no comfort in their concluding statement that "they [physicians] can still get training, but it may not be the training they want." Is this what we — physicians and future patients — want?

I am glad that Sandy Robertson gave us the truth: "No subject is more fraught with anger and frustration than their [Canadian physicians] current inability to enter a new post-

Physician fees: tale of 2 countries

The article "MD fees much higher in US" (*Can Med Assoc J* 1997;156:960) included a table that detailed some of the discrepancies in medical fees between the US and Canada. However, author Lynda Buske did not include the specialty of diagnostic imaging. I am well aware of gross differences between the 2 countries in fees for our specialty as well. This article prompted me to contact a colleague who graduated from a Canadian residency program at the same time as I did and now works in Charleston, Ill. From information supplied by my colleague and from the 1992 fee schedule of the Ontario Health Insurance Plan, I have pieced together an addendum to the table (Table 1).

Once again, the numbers reveal what an incredible bargain the Ontario Ministry of Health is getting from the physicians of Ontario; in this case, Ontario radiologists.

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Table 1: US and Canadian physician fees for selected diagnostic imaging procedures

Procedure	US fee, converted to Can$: Minimum (Medicare)	Maximum (private insurance)	Median (minimum + maximum/2)	OHIP* fee 1992–present
Chest radiograph	13.60	54.40	34.00	8.80
Mammogram	NA†	68.00	68.00	20.20
Needle localization for lumpectomy	87.04	272.00	179.52	46.50
Nuclear-medicine ventilation–perfusion scan	51.68	217.60	134.64	50.35
MRI scan of the lumbar spine	91.12	394.40	242.76	96.35
CT scan of the head with and without contrast agent	77.52	353.60	215.56	71.90
Obstetric ultrasonographic scan				
Uncomplicated	47.60	217.60	132.60	29.10
Multiple gestation	121.04	400.08	260.56	29.10
Biophysical profile	47.60	217.60	132.60	0
Cord Doppler analysis	5.44	171.36	88.40	0

*OHIP = Ontario Health Insurance Plan.
†NA = not available.