Exploring **Smoking Trends**

Dr Martin Raw.

Interview With Dr Martin Raw

Dr Tan Hooi Hwa

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Dr Martin Raw received his undergraduate training in Psychology and Philosophy from Oxford University, and post graduate training in Philosophy from London University. He obtained his PhD in smoking cessation from London University.

He is a recognised expert in the field of evidence-based treatment for tobacco addiction, and the use of nicotine replacement therapy (NRT). In the 1970s, he developed the treatment of smokers in groups, and started experimenting with nicotine chewing given as a treatment aid. He is the author of the original study that showed that nicotine gum worked, published in the 1982 issue of the BMJ.

Possibly, his most influential work to date has been the development of clinical guidelines for health service on the treatment of dependent smokers, as published, with co-authors, in Thorax Dec 1998. Those guidelines set out the scientific basis for treating smokers through the health service, resulting in the setting up of new treatment services for smokers in the National Health Service (UK).

He is the author of the new BBC paperback "How to Stop Smoking and Stay Stopped" launched on No Smoking Day in Britain on 8 March 2000.

Dr Raw was in Singapore recently to participate in a Symposium on "New Strategies In Smoking Cessation", which was very well attended. It was presented that approximately 100 million people died from smoking in the 20th century, and based on current trends, 1000 million will die from smoking in the 21st century. It was estimated that by the year 2025, 10 million people will die from tobacco related diseases.

In the following interview with Dr Raw, he elaborated on issues relating to the latest trends in smoking patterns, smoking addictions and treatment strategies:

Q. What are the most disturbing trends in smoking patterns in the world generally?
A. The fact that tobacco consumption is increasing; decreasing only in a few of the industrialised developed countries, but especially in the developing world, it is increasing. It is also beginning to increase in women, even in areas of decreasing consumption (Japan is an example). Finally, smoking is not decreasing in young people; even in the UK, there is in fact a small increase. One of the main reasons is the marketing by the tobacco industry.

Q. Can you comment on tobacco smuggling, as you are the co-author of "The true extent on tobacco smuggling" in 1995?
A. There is a huge amount of it still going on. The import and export statistics suggests that a third of global tobacco exports disappear into the illegal contraband market, which is a fantastic amount.

Q. In the 21st century, can anything be done to curb these trends?
A. I am cautiously optimistic that a lot can be done to change these trends. To really change things, action has got to be done at an international level, with collaboration between different organisations internationally. One of the things happening now is that the World Health Organisation (WHO) is developing a framework convention on tobacco control, which is an international initiative with protocols on tobacco advertising, and smuggling. There will also be something on treatment of tobacco dependency and regulations on control of tobacco advertising and smuggling which has to be tackled internationally.

Q. How should we approach this at a national level?
A. I have the impression you are doing a lot of good things in Singapore. There is a low rate of smoking in women but in young women it is on the rise. Banning tobacco advertising is very important

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but it is very difficult to make it genuinely comprehensive. For example, to ban all forms of indirect tobacco advertising or "brand stretching", i.e. the use of brand names on other products (e.g. clothing, package holidays). It is quite difficult legally.

Taxation policy, where cigarette prices are made high each year, is a beneficial health measure, and also economically.

Restrictions on smoking in public places is very useful; you have those here. They make a social statement on smoking acceptability; they also encourage people to stop. We have internal evidence from tobacco companies, from evidence in court cases, that the tobacco industry fears restriction on smoking in public places; anything which makes smoking less socially acceptable is a threat to them.

It is important, as smoking is an addiction, to have good programmes to help dependent smokers stop. It is an appropriate role for health care systems to provide.

Q. Can you elaborate further on the addiction problem?

A. Addiction experts will say that nicotine addiction is the essence of smoking dependence. This is, according to many experts, the strongest of all addictions, even more than heroin or cocaine. It is a classical addiction with all the withdrawal symptoms, craving, difficulty in stopping. It is something that the tobacco industry will not admit to. The spontaneous cessation rate in Britain over one year is between 1%-3%, which is incredibly low. Once a young person has started smoking, there is only a small chance of stopping spontaneously before they are very old. It is an addiction therefore, which should be taken seriously by the health care system and help should be made available to help people stop smoking.

Q. Could you comment on the treatment strategies?

A. In my country, the health service is just beginning to take the issue seriously and recognising that people deserve help to stop smoking. We are developing treatment services to help them do that. I am very pleased with that, as it recognises the idea that smoking is not a habit, which people can choose to do and choose to stop. It is something people take up when they are young, and they cannot give up when they want to, or need to. It then regularises it and makes it like alcohol dependence, or illegal drugs where you can get help through the health system, if you need it.

There is a huge evidence base now that tells us what kinds of treatment work, based on a very large body of research conducted over 40 years or more. There are several countries now which have developed evidence based guidelines, e.g. in the UK, based in part on American guidelines in 1996.

In summary, the evidence recommends brief advice from primary care physicians, more intensive support in treatment clinics and pharmacological therapy (two at the moment: nicotine replacement therapy and bupropion, an antidepressant). Very few other treatments have been shown by research trials to work. It is a rather short list, but it is cost effective.

Q. Is the strategy effective regardless of the number of cigarettes smoked?

A. It is more or less a blanket approach, as there is not much evidence of the need for matching treatment to smoker. It is slightly different if you are talking about NRT products. There is no strong evidence that one NRT product is more effective than the other, except for some evidence that the 4 mg gum is more effective in heavy smokers.

Q. What is the role of the primary care physician?

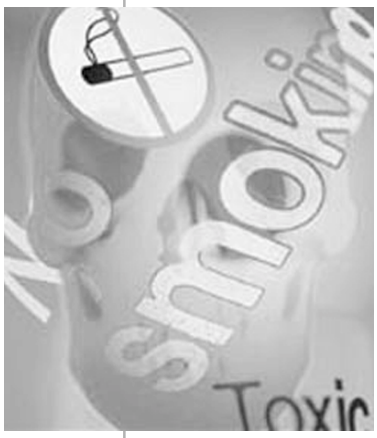
A. It is very important for the primary care physician to raise the issue with their patients. They ought to be aware of the smoking status of their patients. It is a ridiculously obvious but important point, as health care physicians ought to regard smoking as a basic piece of data, and should always appear in medical notes. It would be quite a big step forward if doctors could do that. Unfortunately, it is not done routinely.

Q. Is it because doctors themselves smoke?

A. No, I don't think so. In Britain, only 9% of doctors smoke, quite low. But I think the role of the primary physician in record keeping and raising the issue, is important. I hate to admit that in Britain, we have not been very successful in engaging GPs and persuading them to make a significant contribution in this issue. There are many reasons for this, viz, structural and funding issues that have not been addressed. Ideally, they should be able to refer patients to treatment services.

Q. What about the organisation of the Specialist Clinics?

A. Ideally, this is how it should work: Primary care is a gate keeping function, referring on to specialist centers. Funding is important for the development of the centers. I don't know how "specialised" these services need to be. There are



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A Tribute to

Dr Lee Kng Swan

Departed 8 May 2000

Dr Pang Weng Sun, Honorary Secretary,
Society for Geriatric Medicine (Singapore)

Dr Lee Kng Swan graduated with an MBBS from the University of Singapore in 1979 and obtained her Master of Medicine (Internal Medicine) from the National University of Singapore in 1986. In 1991, she was admitted as a Fellow of the Academy of Medicine, Singapore and her last appointment was as a Senior Consultant in Geriatric Medicine, Changi General Hospital.

One of the early local pioneers of geriatric medicine, Kng Swan trained in Dunedin and Wakari Hospital, Dunedin, New Zealand from 1988-89 with a special interest in elderly services in the community. She returned to work in the Department of Geriatric Medicine in TTSH in 1990 before taking up a post in National University Hospital the following year. In 1991, Kng Swan pioneered the first community based continence clinic in Tampines Senior Citizen's Health Care Centre (SCHCC) under Home Nursing Foundation. This model of bringing continence care to the elderly in the community was subsequently expanded to 6 other SCHCCs in Singapore.

In 1993, Kng Swan became Medical Director of Hua Mei Mobile Clinic, Tsao Foundation, and started the first community based geriatric assessment team in Singapore. Over a 6 year period, she built up a strong home care programme supporting frail elderly in their homes before moving on to Changi General Hospital in 1999.

Dr Mary Ann Tsao, CEO of the Tsao Foundation said, "I have always appreciated the phenomenal leap of faith Kng Swan had taken to leave a safe and secure position at NUH to join the Tsao Foundation, and it is a reflection of her deep commitment to the elderly patients that she served. Through the patient and loving way she worked with the elderly, as well as the care and concern she expressed for her team, all of us at Tsao Foundation came to love and respect her deeply as an extraordinary person who is not only a skilled doctor, but also a kind, generous, compassionate and caring friend."

Her love for the elderly and commitment to their care led to her active participation in several committees and voluntary organisations. She served in the National Policy Committee on the Family and Aged, Society of Geriatric Medicine and was a long time supporter of Gerontological Society, holding the post of Vice-President for two terms in 1991/1992 and 1994/1995. With her wide experience, she became a key organiser and lecturer in the Graduate Diploma in Geriatric Medicine course and the Novartis Foundation Intensive Course in Geriatric Medicine.

Kng Swan always had a positive outlook in life and approached her work with great enthusiasm. In the words of her colleagues from Hua Mei Mobile Clinic, "she was a wonderful boss, friend and mentor...always patient and caring, especially towards new staff regardless of professional status. Both staff and patients loved her jovial personality and her infectious outburst of laughter never failed to bring a smile to everyone around. A person who embraced life passionately and lived it to the fullest: in our hearts, she will forever be our champ."

With her sudden departure, we have lost a friend and fellow geriatrician, a humble colleague who devoted her life to caring for the elderly. Her contributions will go down in the history of geriatric medicine in Singapore. And though she is no longer with us, those smiles of hers will always remain. ■

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specialised skills involved in running stop-smoking clinics and people need training for that. I don't think psychological or psychiatric skills are necessary. In Britain, we train nurses and health education professionals to run such groups. Anybody can do it, given the skills and commitment, with training.

Q. Is there a light at the end of the "smoking tunnel"?

A. In my lifetime, smoking rates will never be really low anywhere in the world. In one sense, I don't see light at the end of the tunnel, meaning everywhere in the world, every country has had to go through the same phase, i.e. smoking rises in the middle class, usually in males first, then followed by females, reaches a peak and then it starts falling, usually in higher social groups (both men and women).

One of the critical reasons why you must have collaborative action at global level (the WHO's role), is to try and shorten that cycle in countries like India, where smoking has been increasing for a while. Now, there is increase in lung cancer, chronic lung diseases and TB deaths in smokers.

Eventually, we can get to the stage to limit the damage, and have the prevalence rate in the next 10 years. ■