

Virtual Mentor

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CLINICAL CASE

“...Not as I Do”

Commentary by Stephanie Toth, MD, and Sonja Boone, MD

It was a hot August afternoon. After a long day of dialysis assessments at a large academic medical center, Dr. Jones, an attending-level nephrologist, stopped at a nearby convenience store on his way home to make a last-minute purchase. A group of teenagers was in the store buying snacks. Dr. Jones also noticed a new cardiology fellow who was wearing his white coat and scrubs, probably on his way home after a day in the cardiac cath lab. In full view of the teenagers, the young cardiologist purchased two packs of cigarettes and lit one up in a nonchalant manner on his way out the door. Watching the receding figure through the store windows, the teenagers began holding their throats and coughing theatrically. The nephrologist, a lifelong nonsmoker, was taken aback by the fellow’s behavior.

Commentary 1

by Stephanie Toth, MD

As if physicians don’t have enough to worry about. Do they really have to concern themselves with how they behave in public after working hours? To whom does it matter what physicians do with their own time, as long as they provide appropriate care to their patients? Are they any different from individuals who work outside of the health care environment? Or, does the physician’s profession hold a certain sanctity in the community that may preclude them from partaking in certain activities? Is the ironic saying, “Do as I say, not as I do,” a convenient phrase to hide behind, or is it quite simply, hypocrisy?

It is a moral question that has been raised before and has regularly riled up proponents on each side. Moralists trumpet physicians as exemplars of responsibility, leaders of a superhuman life who set an example for their community and patients. Others argue that physicians are human too; they are as fallible as the next person, and they too experience stress, death, and emotional hardship. Since physicians are not immune to the daily stresses of life, it is reasonable that they too may succumb to the vices that entice all of us.

In response to an article in the *British Medical Journal* entitled, “Doctors Who Smoke” [1], one reader satirically wrote that, in addition to weeding out doctors who smoke, we should consider barring doctors from practice if they are “obese and sexually reckless.” In a later issue of the journal, a letter writer responded to the article:

On cardiovascular grounds,... we should also discourage those with a sedentary lifestyle; those with diets containing over 30 percent fat; those with a type A or “coronary prone” personality (that probably gets rid of most surgeons); those who drink more than 21-30 units of alcohol a week.... We should also discourage those doctors who parade their suntans, as sunbathing is a reckless and irresponsible activity. They should be allowed laboratory work only [2].

The point is well taken. Physicians are none other than mortal beings. They are not superhuman, and they are most definitely not impervious to the multitude of vices that surround us, be they tobacco, alcohol, or gluttony. More likely, physicians smoke for the same reason nonphysicians smoke: they are addicted. Does this mean that physicians’ actions, flawed though they may be, can be excused as ordinary, inherent human fallibility?

Let us examine the situation our cardiology fellow finds himself in. It is late. He has just finished another grueling day in the cath lab. He may have even had his first adverse event in the lab. Maybe he doesn’t want to be late for dinner with his wife, again. Or perhaps he is just anxious to get home so he can turn the television on and his mind off. Whatever the case may be, it is not his first experience with stress, and it certainly won’t be his last. So he decides to go to the local convenience store to pick up a pack of cigarettes. It could have just as easily been a six-pack of beer, a bag of potato chips, or even a 30-minute detour on the gym’s elliptical. To each his own.

What raises the moral stakes of his situation, however, is that not only does he purchase cigarettes in front of adolescents, he does so in his hospital attire. The irony that a budding *cardiologist* is buying cigarettes is likely to be lost on the group of youths, so let us also forgo it and tackle the more obvious problem: the physician sets a poor example in front of the next generation by purchasing a product with a label that reads, “Smoking kills.” Naturally, the teens would think smoking must be less harmful if they witnessed a physician partaking in the habit. Wouldn’t anybody be inclined to think that the consequences of smoking are less dire if a physician is willing to smoke? The young cardiologist is setting a bad example not only for the youth, but also for the community he serves. Whether physicians like it or not, their profession has been highly revered, both internationally and historically, and, just because today’s practice of medicine has moved away from a paternalistic model, it does not mean that patients no longer look to their physicians for advice. More importantly, advice need not always be spoken. Leading by example can be as simple as taking the stairs, wearing a bicycle helmet, or not smoking.

Suppose the physician counsels patients against smoking and doesn’t condone the habit even though he has fallen victim to it. Has the patient been wronged? After all, smoking is an individual’s choice, is it not? Unfortunately, this cannot be the case for physicians. It is not enough to say simply, “Do as I say, not as I do.” If physicians cannot lead the way against tobacco, nobody can. The field of medicine is one of the

few witnesses to the myriad effects tobacco has on the body. Physicians are often the only advocates patients have against their smoking habit. Every branch of medicine is touched by tobacco—pediatrics, primary care, psychiatry, obstetrics, gynecology, surgery, urology, otolaryngology, pathology—just as every region of the body is touched by the consequences of smoking. A physician, knowing all of this, should feel a moral obligation to quit smoking, if not for society, at least on behalf of his health.

Let us get back to the second, more glaring offense of our young cardiologist: he is wearing his physician's white coat while purchasing cigarettes. It is possible that he was so dazed from his day of cardiac catheterizations that he simply forgot to take his coat off. Possibly so, but whatever the case, he is wearing the universally iconic attire of the medical profession, the white coat. Just as one wouldn't wear it for a night out on the town, one shouldn't wear one into a convenience store to purchase cigarettes. His actions are a sore misrepresentation of physicians as a whole. The white coat demands responsibility and professionalism, and hence the young physician's actions are unacceptable. While it is understandable that one's white coat may feel like a second skin to some, it is important to remember that when donning one in public, the nameless wearer represents all physicians.

Finally, as the teenagers in the scenario thankfully show distaste toward smoking, we will instead focus on the character who has quietly observed the scene unfold before him: the nephrology attending. What role, if any, should the more experienced doctor play in this setting? Do the two physicians know each other? Do they work at the same institution? Should the nephrologist simply speak with the fellow directly? Perhaps direct his concern to the fellow's attending physician? Is it his place to say anything at all? With no obviously correct answer in sight, it is apparent that this scenario could play out a number of ways. Each physician placed in the attending physician's shoes will bring his or her own moral code and comfort level to the situation. Unfortunately, whereas physicians are well versed in the Hippocratic adage "primum non nocere"—first do no harm—they are more reluctant to employ a lesser known Socratic maxim, "primum non tacere," first do not be silent [3]. Approaching the young physician and alerting him to morally reprehensible actions should not make experienced physicians uncomfortable; they are simply counseling another person in a long line of colleagues and patients. It is not enough to wait until medical ethicists redirect our moral weathervanes. Veteran physicians should feel comfortable enough to speak with a young physician, especially when they witness a public display that sheds negative light on the field of medicine as a whole.

Fortunately, the above situation is not very common; only 2 percent of physicians in the United States smoke tobacco [4]. Nevertheless, the scenario raises the question of whether a physician's actions outside of the workplace should be held morally reprehensible if they contradict medical advice. It is impossible to claim that the 2 percent of physicians who smoke tobacco products lack integrity as medical professionals. Though a personal choice, it is not the only one. Perhaps they chose to start smoking years earlier and have been unable to gain control of the addictive

habit. As elucidated in the most recent amendment of the physician's oath, "my colleagues will be my sisters and brothers," physicians have a moral obligation to help not only their patients, but also each other [5]. While it may seem rude or intrusive, what is the long-term harm in asking: "Have you thought about quitting?"

References

1. Chapman S. Doctors who smoke. *BMJ*. 1995;311(6998):142.
2. Sudbury P. Letters: Doctors who smoke. Why not exclude doctors with other unhealthy habits too? *BMJ*. 1995;311(7010):945.
3. Dwyer J. Primum non tacere. An ethics of speaking up. *Hastings Cent Rep*. 1994;24(1):13-18.
4. Smith DR, Leggat PA. An international review of tobacco smoking in the medical profession: 1974-2004. *BMC Public Health*. 2007;7:115.
5. World Medical Association. WMA Declaration of Geneva. <http://www.wma.net/en/30publications/10policies/g1/>. Accessed September 22, 2011.

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Commentary 2

by Sonja Boone, MD

It might be surprising to learn that 2.3 percent of physicians in the U.S. smoke cigarettes [1]. It is even harder to believe that in 1946 there was a Camel cigarette ad with the headline "More Doctors Smoke Camels Than Any Other Cigarette!" and citing a nation-wide survey of doctors as support [2]. As the nation attempts to focus efforts on disease prevention, it is imperative that we understand why even the 2.3 percent of physicians who smoke remain addicted, knowing what they know about biochemistry of nicotine.

While this case seems to be straightforward, there are several factors to consider. The smoker is a physician colleague who is addicted to nicotine and willing to ignore the standards of professionalism in order to have a cigarette. How would one approach such a colleague?

There are at least four perspectives to consider:

1. A "purist" perspective (No one should smoke; smoking is bad for one's health.)
2. A professionalism perspective (Doctors, especially, should not smoke, and those who do should not smoke in public where they are likely to be recognized as doctors.)
3. A beneficence view (The individual's inability to quit smoking must be due to excessive stress; the smoker may need help.)

4. A respect for autonomy view (The individual has a right to make his or her own life decisions, be it smoking, not eating well, not exercising, as long as he or she is not directly harming others.)

The view or perspective one adopts determines the extent to which one feels justified in intervening in the cigarette-buying cardiologist's affairs.

If one adopts the purist, professionalism, or beneficence view, one is likely to intervene. Only the radical respect for autonomy view supports nonintervention. I believe that intervention is justified in this instance and that an approach that entails empathy for the cardiology fellow's tobacco addiction is best—a hybrid of the professionalism and beneficence views. Still, one does not simply walk up and inform the cardiology fellow that smoking in front of others while wearing scrubs represents less-than-desirable professional behavior. The nephrologist could, however, walk up and mention that they both work at the same hospital and ask what sort of day the cardiologist had. This could lead to further questions about work and life.

Studies have shown that physicians are powerful role models for patients and that physicians who engage in healthy behaviors are more likely to counsel their patients on such behavior [3]. Given this information, the fact that the cardiologist was smoking in front of “tweens” further argues for intervention. Children from age 12 years into their early 20s are highly impressionable, and they are particularly vulnerable to exposure to addictive substances such as tobacco and alcohol [4]. The cardiology fellow has actually exposed these young “tweens” to a harmful substance and set a bad example as a professional.

Overall, an intervention in this case will require compassion, empathy, and establishing rapport and therefore trust in order to convey a message that smoking is harmful to self and others and is less-than-professional behavior.

References

1. Sarna L, Bialous SA, Sinha K, Yang Q, Wewers ME. Are health care providers still smoking? Data from the 2003 and 2006/2007 Tobacco Use Supplement-Current Population Surveys. *Nicotine Tob Res.* 2010;12(11):1167-1171.
2. *LIFE*. January 7, 1946: 102.
http://books.google.com/books?id=BEkEAAAAMBAJ&pg=PA21&dq=life+magazine+January+7,+1946&hl=en&ei=BJI7Tq7wCcHksQKT8tHBAw&sa=X&oi=book_result&ct=result&resnum=1&sqi=2&ved=0CDUQ6AEwAA#v=onepage&q=camel&f=false. Accessed September 22, 2011.
3. Lobelo F, Duperly J, Frank E. Physician activity habits of doctors and medical students influences their counseling styles. *Br J Sports Med.* 2009;43(2):89-92.
4. Shute N. How to deploy the amazing power of the teen brain. *US News and World Report*. November 26, 2008. <http://health.usnews.com/health->

news/family-health/brain-and-behavior/articles/2008/11/26/how-to-deploy-the-amazing-power-of-the-teen-brain. Accessed September 12, 2011.

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