
Let the patients smoke: a defence of a patient privilege

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Author's abstract

I examine two kinds of arguments in favour of imposing restrictions on smoking by hospitalised psychiatric patients. First, I look at patient-centred arguments in favour of restrictions. These arguments focus on the benefits that patients will receive if their smoking is stopped or curtailed. Second, I examine arguments that seek to justify restrictions by citing the costs that smokers impose on others. Neither kind of argument justifies any meaningful restrictions on the smoking of hospitalised psychiatric patients.

Smoking by patients is a matter of increasing clinical concern. On the whole, increasingly restrictive policies towards smoking have prevailed. Various hospitals and health care facilities have adopted restrictive smoking policies. For example, in the United States the Indian Health Service (IHS) has recently forbidden smoking in its facilities (1). Numerous other prominent US hospitals also limit or forbid smoking on their premises (2).

So far, the most notable exception to this prohibitory trend has been psychiatry (2). Anybody familiar with the milieu of mental hospitals will understand why: psychiatric patients are frequently judged too emotionally fragile to cope with smoking restrictions (2). More important, are facts about the psychiatric patient population.

Psychiatric patients smoke. Recent surveys reveal that 88 per cent of schizophrenic patients smoke and that 70 per cent of bipolar patients smoke (3). Only bureaucrats too busy monitoring triumphs of regulatory compliance could fail to notice that psychiatric hospitals, especially public hospitals, are smoke-filled.

Heavy smoking by psychiatric patients has occasioned alarm among clinicians. Many clinicians would like, if possible, to adopt the smoking policies that are becoming common in regular hospitals (1,4). Institutional pressures to restrict smoking by

psychiatric patients are gaining strength.

Proposed restrictions take various forms. The mildest restrictions recognise that psychiatric hospitals have too frequently encouraged smoking (4). Use of cigarettes as reinforcers to gain patient compliance with hospital regimens is a norm. At Lakeshore Mental Health Institute in Tennessee, for example, staff until recently have used cigarettes as game-prizes or elements in behavioural modification programmes.

Mildly restrictive smoking policies eliminate the routine use of cigarettes as positive reinforcers. Unfortunately, at least at Lakeshore, this practice has not yet had any discernible influence on the amount of smoking.

More restrictive policies limit patient access to cigarettes. Here there are variations. The least restrictive limit the sale of cigarettes on hospital grounds to low tar and nicotine brands, with high nicotine brands being proscribed. Limiting policies admit other variations. Cigarette sales on hospital grounds could, for example, be forbidden. Or patients could be limited to smoking at only certain hours and in certain places, a common practice at present. The most extreme hospital policy would simply ban smoking.

Though nobody doubts that restrictive smoking policies improve the health of psychiatric patients, clinicians should still examine the *moral* rationales for limiting smoking by hospitalised psychiatric patients; especially since psychiatric patients, unlike other patients, may well have to stay in hospital even if they express a desire to leave. And for some mental patients, in particular long-term chronic and geriatric patients, the hospital is often a home.

Two kinds of rationales for restrictive smoking policies need to be examined, and they need to be examined in the context of the psychiatric hospital. The first kind is patient-centred. This rationale does not concern itself with benefits to others. Rather, the sole concern is to defend smoking restrictions by citing the benefits that the patient will receive. The second kind is other-centred. Here the rationale focusses on the benefits that will go to others if patients have their smoking restricted. Arguments based on the harmful effects of secondary smoke to nonsmokers are typical of other-centred rationales. In practice, these

Key words

Smoking; patient rights; psychiatric patients.

arguments are usually advanced in tandem. For clarity's sake, the rationales should be examined one at a time; first, then, to patient-centred rationales.

Smoking is indisputably dangerous. Smokers put themselves at far greater risk of dying prematurely. Smokers have fastened upon a reliable means of turning their lungs into bags of snot and pus, their digestive tracts into oozing sores, and their cardiovascular system into a reliable source of income for cardiologists. Out of every 100 smokers, one can safely bet that 25 will die prematurely (6). Since mental hospitals have an obligation to put their patients' best interests first, and smoking endangers a patient's health interests, hospitals have *some* responsibility to restrict smoking.

The fiduciary argument against smoking admits of two forms. On the first form, a hospital's fiduciary responsibilities include beneficently-grounded duties to confer benefits on patients when doing so does not impose onerous costs on either the hospital or the patient. A hospital's obligation to have staff force a patient to walk following surgery or to supply a healthy diet, rather than whisky and sirloin, are two examples. Restrictive smoking policies might be thought to be another, since patients stand to gain some benefits from not smoking while hospitalised. The second form of the fiduciary argument holds that hospitals have beneficently-based duties to prevent harms to patients. For example, feeble, disoriented patients might be placed in restraints to prevent them from falling from their beds during the night. Neither form of the fiduciary argument is adequately compelling to justify strong restrictions on smoking by psychiatric patients.

The beneficently-based justification of a restrictive smoking policy to provide a benefit runs into a formidable problem. Though the desire to confer benefits on patients is laudable, conferring a benefit is not of itself a sufficient justification for restricting a patient's liberty. When conflicts between beneficently-grounded duties and liberty arise, it is necessary to offer arguments to show that beneficence should take precedence over liberty. One might show, for example, that patients who refuse to rise from bed after surgery are being irrational. They want to recover. They do not want to develop pneumonia. These wants cannot safely be achieved if patients remain addicted to immobility. Typically beneficial hospital regimens help patients to achieve their own therapeutic goals, while minimising the likelihood that they will suffer harms deleterious to the achievement of their therapeutic goals. By contrast, smoking restrictions, though they benefit patients, do not facilitate psychiatric patients' recovery from the condition that brought them to the hospital in the first place. The restrictions do not improve the likelihood of the psychiatric patients achieving their therapeutic goals. And if the hospital's goal is merely to provide a benefit, without also lessening the likelihood of harms to patients that will interfere with their recovery, beneficence is not adequate to justify restrictions on liberty.

To see the inadequacy of such a justification, an example may help. If patients recovered as quickly and safely from surgery whether they languished in bed or got up to walk, nobody would seriously contend that staff should force them to walk anyway, on the beneficent grounds that walkers leave the hospital with gamelier legs. To justify acts of positive beneficence that limit a patient's liberty, the beneficent act should help improve the condition for which the patient is being treated, while lessening the likelihood of the patient's suffering an imminent harm that could occur if the beneficent act were not performed. Hence positive beneficence does not justify restricting smoking among psychiatric patients. Restricting their smoking does not further the treatment of the condition that brought them to the hospital. Nevertheless, it may be that a beneficently-based justification that focusses on the dangers of smoking will work.

Unfortunately this argument from danger to patients does not work. Though patients will enjoy better health if they smoke less or quit, the obligation hospitals have to safeguard their patients' best interests cannot by itself justify restrictive smoking policies. For better or worse, smoking is an activity open to adults. Psychiatric patients are typically inveterate smokers who have no desire to have others force them to limit or stop their smoking. And this is so even though the Surgeon General has reported that 90 per cent of smokers have tried to quit (7). Would-be quitters plainly did not seek out environments that would force them to quit, since only 36 per cent succeeded in quitting (8). Why psychiatric patients, unlike other smokers, should be forced to receive treatment for their smoking requires an explanation. Incompetence might be one explanation.

Though psychiatric patients are sometimes incompetent to make decisions about their medical care, that is because serious grounds usually exist for doubting that a patient refusing treatment would continue to refuse treatment if competent. Consequently, psychotic patients receive medications such as phenothiazines for their psychosis or insulin for pre-existing or newly diagnosed diabetes even when they do not (currently) want them. Treatment aims to restore to patients the ability to live their lives as they see fit. But patients, as is readily observable, smoke whether or not they are incompetent. Their smoking behaviour is not, say, like the writing of obscene letters or the refusal of insulin, an uncharacteristic behaviour caused by an underlying disease process. Instead, patients' histories offer evidence about what their competent choices regarding smoking are. And their choice is to smoke. In short, in the ordinary case, there is no evidence that psychiatric patients want to be treated involuntarily for their smoking, while there is plenty of evidence that they do not want to be treated. Even if smoking is a treatable psychiatric disorder, patients have the right to refuse treatment unless something about nicotine dependency makes it

impossible for patients to make competent decisions about treatment.

Accordingly, some clinicians at meetings I have attended on this subject have argued that smoking is a disease that makes competent choices about quitting or continuing impossible. In particular, the addictive properties of nicotine mean that smoking is one of the diseases that clinicians have an obligation to treat (6,9). Smokers simply cannot make competent decisions about the habit.

The grounds for the foregoing argument are underwritten by familiar considerations favouring weak paternalism. It is sometimes permissible to prevent people from acting on decisions that are likely to cause them harm and that they are incompetent to make. A standard justification for weak paternalism is that it will prevent people from acting on decisions that they may well regret when they regain their competence. And given the extraordinarily high prevalence of smoking among psychiatric patients, perhaps it is reasonable to entertain the hypothesis that their disease process undermines their capacity to make autonomous decisions about whether or not to smoke.

The reply to this is straightforward. Just repeat what has previously been said. Competent patients have a right to refuse treatment they do not want. Hence a straightforward application of the traditional case for weak paternalism is absent. It is not clear that smoking restrictions will necessarily prevent patients from acting on decisions which when competent they would regret, since the competent may and often do elect to smoke. The claim that the addiction, or less controversially nicotine-dependency, makes them incompetent to refuse treatment is at best dubious. Nobody has suggested that people who are not psychiatric patients should be treated against their will for their cigarette addiction. As already observed, 90 per cent of smokers have tried to quit, but no evidence exists that the 90 per cent want to be forced to quit. It is simply fatuous to suggest that cigarette smoking is proof of incompetence to make decisions about whether to enter a smoking treatment programme. Smokers make that kind of decision frequently. Many do elect to be treated for their nicotine-dependency. And even though psychiatric patients are more likely to be smokers than a member of the general population, that provides no licence for clinicians to force patients to stop smoking. Smoking has not been demonstrated to have anything to do with the patient's disease process *per se*. Many pressures on wards probably do encourage patient smoking. Cigarettes figure prominently in the token-economies of psychiatric hospitals. Moreover, staff have historically used cigarettes as rewards and punishments in efforts to secure patient compliance with ward routines. If staff claims that weak paternalistic interference with psychiatric patients who smoke is justified, the onus is on them to show that the hypothesis that smoking results from the patient's disease process is justified.

To date, there has been no such showing. So, given what is presently known, there is no good reason to think that smoking makes a person incompetent to make treatment decisions about entering into a programme to quit smoking or that psychiatric patients smoke because of their illness. Consequently, their refusals of treatment for smoking should be honoured. The conditions for weak paternalistic interference to prevent a harm have not been satisfied.

One other patient-centred rationale for restrictive policies sometimes emerges. Smoking decreases the blood levels of neuroleptics (10). As a result, schizophrenic smokers should receive larger doses of neuroleptics than they would have to if they did not smoke. In theory this is true, but is there evidence that non-smoking patients *in fact* receive smaller doses of neuroleptics than smoking patients? On the contrary, when Resnick and his associates banned smoking on a ward, they reported 'no readily discernible changes in antipsychotic drug dosage [or] PRN psychotropic medications dispensed' (5). But suppose it were so. One still has to show that it is permissible to force the patient to stop smoking. A cardiologist undoubtedly wishes her hypertensive patients did not smoke, but she cannot force them to quit. All patients, psychiatric as well as non-psychiatric, ought to be informed of the benefits that quitting will have for their treatment. If they refuse to listen, they can expect that they will not get as good a result. No patient-centred reason exists for singling out psychiatric patients for forced treatment of smoking.

If it is replied that doctors do force regimens on patients who are hospitalised, the rejoinder is obvious. First, it is not at all obvious that that is an appropriate exercise of medical authority. If any psychiatric or non-psychiatric patient's hospitalisation is likely to be protracted, it is less obvious that doctors do have a warrant for forcing undesired treatments or regimens on patients, unless one of two conditions is met. In the case of benefit-conferring treatments or regimens, the doctor should be able to show the undesired benefit helps to treat a condition for which the patient would competently want treatment, while lessening the likelihood of an imminent harm that the patient would not wish to suffer and that would likely occur if the patient did not receive the benefit. In the case of treatments and regimens designed to save the patient from harms, the doctor should be able to show that the prevented harm is one that the patient would wish to be prevented from suffering if competent. Neither of these conditions is ordinarily satisfied in the case of psychiatric patients.

Second, restrictions in non-psychiatric hospitals are typically aimed at facilitating a patient's recovery. But even in ordinary hospitals, the purpose of universal bans on in-hospital smoking are not patient-centred. They are best understood as efforts by the hospital to provide a safe environment for its non-smoking patients and staff, and sometimes to promote health values. But these are other-centred justifications for

restrictive smoking policies.

This concludes my review of patient-centred arguments for restrictive smoking policies. I think I have shown that no patient-centred justifications exist for forcing patients to quit or for even restricting their smoking. I turn now to other-centred justifications.

Other-centred justifications have two variants: one focusses on the damage smokers do to non-smokers: the other on the social costs smokers impose on everybody.

The damage smokers do to non-smokers is beyond dispute. Though disagreement exists over how serious the damage is, nobody can reasonably deny that some damage occurs (11). At a minimum smokers smell up a room. Evidence also exists that those who suffer prolonged exposure to sidestream smoke are more likely to get the very diseases that smokers themselves are more likely to get. A recent US study found that non-smoking wives who had smoking husbands were at 34 per cent greater risk of developing lung cancer than if they had husbands who did not smoke (11). Given all this, there is an excellent other-centred justification for restrictive smoking policies. They protect non-smokers. Is that reason enough to justify restrictive policies in a psychiatric hospital?

The answer to that question will depend on how restrictive the policies being proposed are. The most an argument based on safety to non-smokers shows is that smokers should not be allowed to smoke wherever they feel like it. The most restrictive smoking policies, such as total bans of smoking on wards or hospital grounds, prohibitions of the sale of cigarettes on hospital grounds, or limitations of sales to low-tar and nicotine brands, are without justification if the safety of non-smokers is the aim. Insofar as the protection of non-smokers is the rationale for restrictions, only moderate restrictions emerge as justifiable. For example, a ward could justly limit smoking to a particular room, or, as some wards at St Elizabeth's Hospital do, to a patio area outside the ward. Incidentally, this approximates the status quo in many psychiatric hospitals. The new prohibitory trend has, unfortunately, refused to content itself with calling for these manifestly reasonable restrictions, but has instead called for prohibitions on smoking. This lust for prohibitions has been especially distressing to the many chronic psychiatric patients for whom the psychiatric hospital has become a home. If at home, these patients would have the freedom to smoke. But of course it must be borne in mind that at home smoking patients would not be exposing those who are not members of their family to smoke. Again, though, a compromise solution is available. Staff need only impose restriction on where patients may smoke, even families have been known to do as much. So, the most restrictive smoking policies remain without an adequate justification in terms of safety to non-smokers. What justification is left?

In addition to putting others at greater health risk, smokers do impose social costs on everybody. Fire

insurance costs more. Custodial work must be more extensive. One could go on (6).

Let's grant, then, that smoking increases social costs to others. Does that in itself justify more restrictive smoking policies in mental hospitals? Here the involuntary status of many patients is relevant. Many chronic patients will spend the better part of their lives in hospital. Within hospital the opportunities for amusement are limited, as is the capacity of many patients to take advantage of what distractions there are. For such patients, smoking is a solitary diversion that they find to be a satisfying way to while away the hours. That staff do not find that to be a satisfying way to spend time does not prove that it is an unsatisfying way for the patient to spend time. For at least some patients, smoking may be as satisfying a diversion as they are regularly capable of enjoying. Since the State has framed laws that impose a severe deprivation of liberty on psychiatric patients, the added costs that result from in-hospital smoking are a negligible compensation, especially when the State endures these costs in many other settings, such as private State offices. If it is objected that no right to compensation follows from deprivations of liberty that are justifiable, the following observation is appropriate. When the State does limit a person's liberty, it should do so in a way that imposes as small a deprivation of liberty as feasible. Obviously, there are limits on the costs the State may reasonably be expected to bear, but since the State is already carrying the costs of letting patients smoke, it is disingenuous to contend that the State cannot afford to let psychiatric patients smoke in areas where they would do no harm to non-smokers. Consequently, arguments based on the costs of smoking do not have sufficient weight to justify the most restrictive smoking policies.

To sum up, the above arguments are not meant to show that restrictions on patient smoking are never appropriate. Anybody who has served in a psychiatric hospital knows that they often are. When smoking complicates the diagnosis of a patient at intake, it may be necessary to prevent the patient from smoking until a diagnosis is possible. It may even be that bans on smoking on acute wards where patients' stays will almost always be short are justified if the costs of providing a segregated smoking area to patients are great. As I again wish to emphasise, these arguments do not show that patients should be able to smoke wherever they want, and that means that they will also not be able to smoke whenever they want. For the comfort and safety of others it is surely permissible to limit patient smoking to particular rooms. What these arguments do show is that total bans on smoking for hospitalised psychiatric patients are morally indefensible, and that restrictions on patient smoking should be mindful of the special circumstances of the psychiatric patient. In any case, that patients are hospitalised does not entitle clinicians to force them into treatment for smoking. Psychiatric patients, like all patients, may refuse treatment for some of their

illnesses. But psychiatric patients, like all persons, have no entitlement to smoke wherever they please.

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References

- (1) Leads from the MMWR. Indian health service facilities become smoke-free. *Journal of the American Medical Association* 1987; 258: 185.
- (2) Dingman P, Resnick M, Bosworth E, Kamada D. A non-smoking policy on an acute psychiatric unit. *Journal of psychosocial nursing and mental health services* 1988; 26: 11-14.
- (3) Hughes J R, Hatsukami D K, Mitchell J E, Dahlgren L A. Prevalence of smoking among psychiatric outpatients. *American journal of psychiatry* 1986; 143: 993-997.
- (4) Resnick M, Bosworth E E. A survey of smoking policies in Oregon psychiatric facilities. *Hospital and community psychiatry* 1988; 39: 313-315.
- (5) Resnick M, Bosworth E E. A smoke-free psychiatric unit. *Hospital and community psychiatry* 1989; 40: 525-527.
- (6) Goodin R E. The ethics of smoking. *Ethics* 1989; 99: 574-624.
- (7) US DHHS. Surgeon general. *Smoking and health*. Washington, DC: Government Printing Office, 1979.
- (8) Benfari R C, Ockene J K, McIntyre K M. Control of cigarette-smoking from a psychological perspective. *Annual review of public health* 1982; 3: 101-128.
- (9) Gralnick A A. Nicotine addiction in the psychiatric hospital: a preliminary report. *Psychiatric journal of the University of Ottawa* 1988; 13: 25-27.
- (10) Dawson G W, Vestal R E, Jusko W J. Smoking and drug metabolism. In: Balfour D J K, ed. *Nicotine and the tobacco smoking habit*. Oxford: Pergamon Press, 1984.
- (11) US DHHS. Surgeon general. *The health consequences of involuntary smoking*. Washington D C: Government Printing Office, 1986.

News and notes

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