Ontario Medical Association Position Paper

Tobacco, Illness, and the Physician's Perspective

I. Introduction

Tobacco industry products have no safe level of use and are highly addictive. They are also the only consumer products that kill when used as intended by those who make them, and kill half of their long-term users prematurely.[1] No other industry's products have caused anywhere close to the number of deaths and cases of disease resulting from tobacco addiction — more than 13,000 annually in Ontario alone.[2]

Ontario physicians live with these realities day to day. As they prescribe treatment or encourage patients to stop smoking, they also read of advances in tobacco control policy, or hear about the effectiveness of stop-smoking medications. They read these stories of success but continue to deal with health damage and premature death in their practices. So many physicians ask themselves whether society's response to the tobacco industry's products is proportionate to the harm they cause.

For most Ontarians today, tobacco addiction no longer appears to be the omnipresent and unavoidable menace of just a few years ago. Various levels of government have enacted good legislation and funded programs to rid public places and workplaces of second-hand tobacco smoke, help youth to avoid initiation of tobacco use, and educate those addicted about the cessation process. Tobacco control budgets have been generally strengthened, enforcement resources provided and advertising campaigns rolled out.

The province of Ontario has indeed been a leading jurisdiction in efforts to curb exposure to second-hand smoke, and on other tobacco-related issues.

The results of these activities appear in leading surveys: smoking prevalence has declined to under 20% in Ontario during the past two decades,[3] down from prevalence levels approaching 50% in the 1960s.[4]

But even as we celebrate these successes, the prognosis for further advancements is uncertain. Declines in smoking prevalence are flattening. The availability of cheap, untaxed contraband tobacco products is expanding. Retail outlets remain in every community, and the industry is working hard to rehabilitate its negative image through offers of new, "safer" products, and claims of a new, socially responsible outlook.

This paper considers the position of the physician and the patient who today are living with the consequences of tobacco addiction. It is also a call for renewed purpose and direction in addressing this persistent health challenge.

We look at the current state of tobacco control in Ontario, and then consider the position of the physician treating tobacco-induced illness. We also highlight the evolution of the industry behind the widespread prevalence of tobacco-induced disease, assess the effectiveness of our response to it, and call for immediate action on urgently needed remedies.

II. Tobacco Control in Ontario Today

The health evidence which encouraged those addicted to tobacco to quit in large numbers began to emerge in the 1960s. Whatever the

severity of addiction of individuals in the 1960s to the 1980s, it is clear that large numbers quit with or without the benefit of legislation, high taxes, or cessation programs.

Beginning in the early 1990s, Ontario governments implemented increasingly comprehensive legislative, programmatic, and financial responses to tobacco addiction. Sales to youth under 19 were prohibited. Workplaces and public places were made smoke-free (a policy extended to vehicles transporting children under 16 in 2009). Retail tobacco advertising and displays were prohibited. In order to reduce addiction initiation, media and program initiatives intensified targeted messages to young people.

Following the 1994 federal and provincial tobacco tax reductions in response to the smuggling crisis, provincial tobacco tax levels began to climb again. (Ontario's stalled in 2006 as a result of the proliferation of contraband tobacco, discussion of which follows below.)

These advances have led some in the media and the government to ask whether tobacco control is in fact "done." Others ask whether tobacco addiction should be categorized as simply one among many other chronic diseases and associated risk factors, such as hypertension, diabetes, physical inactivity, and alcohol and drug abuse.

The absolute number of Ontario smokers today — about 2.1 million[5] — is a much smaller proportion of the population compared to past decades, but still remains relatively high. Some have asked if this can be due to recent immigration to the province from jurisdictions where smoking prevalence is high. In fact, recent survey research data show that:

- The large majority of Ontario smokers speak English at home (1.8 million);
- Are white (1.6 million);
- Are born in Canada (1.6 million);
- Learned and understood English as their first language (1.5 million).[6]

Despite high incidence of addiction in their countries of origin, the same survey found that 9% of South Asian Canadians, and 10% of Chinese Canadians, reported smoking behaviour levels of prevalence that are considerably below the general population average.[7] The picture is different for Ontario's aboriginals, who make up 5% (or 106,500) of all Ontario smokers, with a 40% smoking prevalence rate.[8]

There are also signs that the impact of efforts to minimize tobacco's effect on Ontario society may have begun to weaken. The table below shows how declines in consumption, which had been relatively consistent during the 1980s and 1990s in Ontario, slowly began to flatten in recent years (other surveys show similar flattening in declines across North America).

In Ontario, this flattening occurred in parallel with the emergence of a new form of tax-free, or contraband, tobacco products in 2004-2005. Unlicensed cigarette manufacturers in Ontario, Quebec, and New York State are distributing illegal cigarettes across Ontario, and have taken up an increasing share of the tobacco market. By 2009, between one in five and one in two cigarettes smoked in Ontario were classified as contraband.[10] Some contraband is actually sold in convenience stores.[11]

Widely available contraband means cheap cigarettes for the average smoker. It deters provincial and federal governments from increasing taxes, thus depriving government of both tax revenue and the most effective means — i.e. price increases

Smoking Prevalence in Ontario: 2001-2008 [9]
Canadian Community Health Survey — Current Smoking (Daily and Occasional)

	2001	2003	2005	2007	2008
All ages	24.5%	22.3%	20.9%	20.8%	19.8%
Age 12-19	16.6%	13.7%	10.7%	10.2%	8.2%
Age 20-34	31.8%	29.3%	27.6%	29.1%	27.8%
Age 35-44	30.1%	28.2%	26.6%	24.7%	23.7%
Age 45-64	23.8%	22.0%	21.6%	21.8%	21.1%
Age 65+	11.7%	9.8%	9.5%	9.2%	9.4%

— of combatting tobacco addiction.

The Auditor General of Ontario found that in fiscal 2006-2007, the province lost in the range of $500 million[12] in uncollected tobacco tax revenue due to the proliferation of contraband cigarettes. Total tobacco tax revenues that year were reported as $1.236 billion.[13] The projection for 2009-2010 is $995 million suggesting that even more tobacco tax revenue may have been lost. With fairly stable smoking prevalence rates over this period there are no other explanations for this decline in provincial revenues.

Contraband also fosters an atmosphere of lawlessness and disrespect for authority in many communities where the trade flourishes. Finally, it undermines existing tobacco control programs and legislation.

Contraband tobacco is much cheaper than licensed tobacco, is free of government taxes, warnings, and many retail restrictions. The cheapest and most prevalent form of contraband is clear plastic bags of 200 cigarettes. These are manufactured and packaged in a half dozen locations in Ontario, Quebec, and northern New York State.[14]

Access to "legal" tobacco industry products is also easy. Thousands of convenience stores and other retail outlets in every community across the province stock and sell these products — in some cases to young people, despite long-standing provincial prohibition of such sale.

The contraband and retail access issues must be dealt with to effectively reduce access to industry products, both in terms of low prices and ease of access. In parallel with these efforts, much more must be done to address the needs of smokers, most of whom do not want to continue using tobacco industry products.

Much attention has been focused over the past decade on the need for a comprehensive and properly resourced smoking cessation system in Ontario, but such a system does not yet exist. On the medications side alone, there are several nicotine-based and non-nicotine-based drug therapies available in a variety of formats and combinations that can assist many smokers at various stages of the cessation process.

The OMA has previously called for wider and easier access to smoking cessation medications.[15] While nicotine replacement therapy can now be obtained off-prescription, and there is a cessation counseling fee code available to family doctors and general practitioners, many of the OMA's other recommendations still await action.

Individual services and programs are certainly helpful. The Canadian Cancer Society's Smokers Helpline is available to provide counseling and referrals to appropriate professionals and treatments. The Ottawa Heart Institute's hospital-based smoking cessation protocol, now adopted by numerous hospitals, provides assistance for smokers facing hospital stays from pre-admission through ongoing post-discharge follow-up. There have also been training programs on cessation counseling made available to some physicians, pharmacists, dentists and nurses, an initiative by anesthesiologists to help patients quit for safer surgeries, as well as the free distribution of nicotine replacement therapy, pilot tested by the Centre for Addiction and Mental Health.

Yet, at the same time, many smokers would like additional help but do not know where to get it, or cannot afford smoking cessation medications, or do not understand that cessation can require multiple quit attempts, and a sustained effort, to be successful over time.

None of the preceding should be taken as a criticism of patients or of the sponsors, but there has been a failure to put a comprehensive cessation system in place, and design it so that any smoker wishing help to quit at any time is aware of, and able to easily access, the system.

Provincial tobacco control funding, which reached a high of $60 million per year through the Ministry of Health Promotion in 2007-2008, has now declined to $42 million per year, a decline confirmed by this Ministry. While the provincial government has promised to protect this continuing investment and renew its tobacco control strategy, pressure for additional funding for other chronic disease management programs will continue, and the future is uncertain.

Ontario's response to the tobacco problem today can thus be characterized both by success and the significant challenges that still must be addressed. Physicians face a similar duality: progress in the evolution of treatments and patient outcomes, but challenges with respect to treatment complexity and resources, as will be described in the next section.

The simple fact is that there are still far too many Ontarians suffering from entirely preventable tobacco-induced illnesses.

III. Physicians and Tobacco Today

Patients suffering from a wide variety of tobacco-induced diseases — particularly cancers, cardiovascular conditions, and primary respiratory illness — continue to occupy physicians' waiting rooms, operating rooms, and intensive care units in large numbers.

Tobacco use accounts for 85% of lung cancers, 30% of total cancer incidence excluding skin cancer, and 30% of cancer deaths.[16] Smoking related cardiovascular disease (CVD) is responsible for more than 6,000 deaths annually in Ontario.[17] Tobacco use is also responsible for 80% to 90% of all cases of chronic obstructive pulmonary disease (COPD).[18]

To many physicians, the progress noted earlier in controlling addiction to tobacco industry products is not reflected in their daily practice experience. On the one hand, physicians enjoy smoke-free public places together with other Ontarians, do not have to see retail tobacco industry product displays, nor are they confronted with industry advertising. On the other hand, they are conscious of the very large number of hospital days still resulting from tobacco addiction — over 2.2 million in 2002[19] — and the cost of fam-

ily physician visits alone, which totaled over $110 million in 2002, and has no doubt risen since.[20] At the same time, the large and relatively static absolute number of Ontario smokers persists:

- The *prevalence* of cigarette use among men in Ontario fell from 49% in the late 1950s and early 1960s to about half that figure (24%) by the year 2000.[21] Use among women trended upward in Ontario till the 1970s, but since then prevalence has dropped by almost half.[22] Today, 19% of Ontarians aged 12 and over smoke cigarettes.[23] But while declines in prevalence are heartening, the absolute number of smokers, i.e., the number of potential tobacco patients, has not declined. There are still about 2.1 million cigarette smokers in Ontario today,[24] with another 200,000 using other forms of tobacco. This is actually greater than the total smokers in the mid-1960s, when smoking prevalence rates were much higher but the population only half what it is currently. In 1965, smokers of all tobacco products in Ontario (including pipes and cigars, as well as cigarettes) totaled 2.1 million.[25] The absolute number of smokers remains unacceptably high — at a level that will continue to place entirely preventable strains on our health-care system for years to come.
- In the early 1960s, there were about 8,000 physicians in Ontario. This number increased to over 23,000 in 2008.[26] While the increase in the number of physicians has roughly paralleled the increase in the population since the 1960s, the absolute number of smokers has remained approximately the same, so it might appear that each physician would have a lesser burden of care for tobacco-related illnesses. As described below, each patient now requires more, and longer, treatment: the burden of care, therefore, remains high.

Whether family doctors or specialist, physicians across Ontario can testify to the dramatic changes to both the number and efficacy of treatments for tobacco-induced diseases in recent years. Discussions with colleagues in the fields of oncology, cardiology and respirology have highlighted two trends in these specialties:

- Both the number and the efficacy of treatments for tobacco-induced illnesses have dramatically improved, particularly in the past 20 years;
- The complexity and the number of physicians involved in deciding and administering treatment regimes for patients suffering from tobacco-induced illness have also dramatically increased. New therapies can prolong life, but are also costly in both provider time and resources.

Several prominent Ontario physicians[27] discussed these changes, and the impact upon their practices, with the OMA. Important themes emerged.

The fact that 2.1 million Ontarians currently smoke cigarettes does not represent the total number of Ontarians who suffer from exposure to tobacco smoke.

Respirology specialist and OMA Respiratory Disease Section Chair Dr. Helen Ramsdale pointed to the far larger number of Ontarians exposed to tobacco: "If you think about the 2.1 million current smokers, how many in the province have been smokers during their life, and how many have been exposed to second-hand smoke? If you think about the numbers that way, those numbers probably double at least."

The impact of second-hand smoke on the health of non-smokers will continue to produce disease for many years. Dr. Yee Ung, a radiation oncologist at Sunnybrook Health Sciences Centre, noted that "in my catchment area, we have a significant Oriental population. And what we're seeing is a lot more lifelong non-smokers developing lung cancer, and they tend to be adenocarcinomas…10% to 15% of our adenocarcinomas are lifelong non-smokers."

There is little recent data on the direct health-care costs attributable to second-hand smoke exposure. The most recent report from the Canadian Centre for Substance Abuse's 2006 study, estimates direct health-care costs attributable to passive smoking in 2002 at $17,873,434.[28]

What is clear is that calculations on the future burden of tobacco-induced illness must include those who are victims of second-hand smoke.

Approaches to treating lung and other cancers, CVD, and COPD (which includes chronic bronchitis and emphysema) have changed dramatically for the better in the past 20 to 30 years, both in terms of available therapies and outcomes.

Lung cancer is the best-known and the most-feared disease outcome from addiction to tobacco industry products, primarily due to a poor survival prognosis. COPD affects a larger number of patients, whose prognosis has improved with new therapies and approaches.

Today, many older COPD patients are given instructions on how to administer specific therapies for their disease, with a corresponding reduction in calls and visits to physicians. While the move to self-administered care in this area has led to fewer physician visits for some COPD sufferers, self-care does not necessarily suit the needs of older patients, whose judgment and other capacities to deal with illness are reduced with advancing age.

Dr. Ramsdale noted that "you can't teach the older population to self-care as well as you can the 50-year-old" — the relevance of this comment can only increase as the Ontario population ages.

Treatment technology has rapidly evolved, leading to greater precision in both diagnosis and treatment, and better outcomes.

The evolution of radiation therapy for many forms of tobacco-induced cancer is a case in point. The advent of stereotactic therapy, for example, has meant that doses can be delivered with much greater precision directly to tumour sites, and

with much less impact on surrounding tissue.

Radiation oncologists are now seeing more patients because referring physicians are more aware that there are newer treatment options available.

Dr. Ung described this evolution: "I've been in practice now for 16 years, and I've seen a dramatic shift. When I first started, there was no proven benefit for adjuvant chemotherapy in early stage lung cancer, and now that's the standard of care. And we were not in the habit of giving aggressive pre-op chemo and radiation followed by surgery for locally-advanced lung cancer, and we're doing more of that. Now, we have more novel therapies, including molecular therapies. Whereas before these patients didn't really respond to treatments, now they're responding to these therapies. And people are living longer."

The same advances characterize cardiology, according to Toronto's Dr. Anthony Graham: "Our ability to keep people going with cardiovascular disease has increased dramatically with advances in care in our area, whether it be thrombolytic therapy, bypass surgery, primary angioplasty, secondary prevention, arrhythmia treatments, or ICDs.

"I've got people who have had advanced coronary disease for over 25 years who are still going. There has been a huge impact on aneurisms, for which smoking is a major factor. People are going to be able to have this type of therapy with much less risk and much greater potential for long-term benefit."

Dr. Graham, who used to say that he "had a job because of the tobacco industry," highlighted the difference between CVD approaches 25 years ago and today: "There were no clinical trials; the concept of treatment to target didn't exist. We could treat hypertension, but we didn't know what the target should be. The concepts of cardiac rehab were really just starting."

Minimally invasive surgery has also meant that patients who were previously not surgical candidates, now are. This means both a higher number of surgeries being performed, and more successful outcomes.

Those with metastatic tobacco-induced cancers can also benefit from new advances. Second-line and now third-line therapies can be provided to patients who are living longer with metastatic lung cancer, with intended improvements both in longevity and quality of life.

While both treatments and outcomes have changed for the better, treatment complexity and attendant costs have also increased.

Tobacco-induced disease directly costs Ontario's health-care system $1.6 billion annually, with acute-care hospitalizations accounting for over half that figure. Indirect costs attributable to tobacco addiction, such as short-term disability and premature morbidity, account for another $4.5 billion in costs to the provincial economy.[29]

The availability of CT scans, MRIs, and even PET scans for treatment of a range of tobacco-induced diseases means both earlier diagnosis and more positive outcomes, but also adds significantly to the cost of treatment.

Dr. Ung noted one example of how newer types of chemotherapy are expensive: "Targeted molecular therapies used in lung cancer require mutational analyses because responses to these drugs can be very dramatic if a patient's lung cancer contains a specific mutation. These therapies are very expensive."

Many patients with lung cancer tend to have a component of obstructive lung disease, and coronary artery problems, which can limit options in terms of giving chemotherapy combined with radiation. These patients can have many co-morbidities that must be dealt with, which in turn increase the complexity of treatment.

Dr. Ung described the work of the multidisciplinary tumour board at Sunnybrook Health Sciences Centre, which meets weekly to review cases and discuss management and treatment protocols:

"The board involves our surgeons, our medical and radiation oncologists, our respirologist, and our diagnostic radiologist. The board increases the amount of time available to thoroughly discuss the optimal treatment for patients. The two-to-three-year survival rate has improved and has gone up to about 20% to 25% at the three-year mark, whereas before it was around 5% to 10%.

"We need to co-ordinate with other specialists, because while patients have significant cardiac problems, radiation oncologists now have technologies to deliver treatment, but we need to be aware of what the potential factors are that might impact upon what the cardiologist does and the cardiovascular surgeons do. So we have to interact more with other specialists outside of the cancer field."

Dr. Graham noted that "providers are involved in looking after these people for a lot longer, and depending upon how many providers we have, that has to be an issue. The fact that these people are older means they're going to have more and more co-morbidities. They're going to require various types of ancillary health care from groups of different providers."

Prevention is also important, but physicians question whether cessation therapies are being made available, and how tobacco addiction will impact chronic disease in the future.

"I see many people who still can't afford to use drugs to help them stop smoking, because the government doesn't cover it," says Dr. Ramsdale, "and they're probably the ones that would benefit the most in a way, because they're already on disability or they're already not working. It's important to help people stop and if you can help people by giving them the drugs to help them stop, that would be beneficial, for sure."

Physicians are also well aware of the range of diseases linked to tobacco addiction and the importance of the new focus on chronic disease management.

"We all know the vast majority of

health-care dollars go towards chronic diseases. And they're all intimately linked to tobacco," says Dr. Graham.

As the health-care system focuses more and more on chronic disease management, it becomes clear that far from diminishing, the impact of tobacco addiction on the health-care system is likely to multiply in coming years.

According to Dr. Graham: "We know that tobacco has a huge accelerating effect on the complications of diabetes, and on the whole issue of peripheral vascular disease, the issue of stroke and coronary disease. I think the idea of linking the whole diabetes challenge that we have to the tobacco issue is an important one.

"You could argue we have made significant inroads in tobacco control, but we certainly haven't done that with diabetes, and it's quickly increasing right now. Many of the 2.1 million smokers in Ontario now have diabetes, or they will in the next five years. This issue is going to cause increased pressure on the system, and increasing issues related to chronic disease."

Dr. Graham's concerns about obesity and its impact on cardiovascular disease are highlighted in three recent reports:

- The 2009 Canadian Heart Health Strategy noted that CVD led to over $22 billion annually in health-care costs and lost productivity Canada-wide in the year 2000.[30]
- The Public Health Agency of Canada estimates that CVD accounts for 17% of all hospitalizations.[31]
- The Canadian Diabetes Association notes that those living with diabetes who smoke are three-times more likely to have a heart attack than people with diabetes who do not smoke.[32]

It is hoped that the Canadian Heart Health Strategy's call for a decrease in the national smoking rate of 25% by 2020 is just a minimum target.

The many advances described above are obviously good news for thousands of patients whose lives are lengthened, and for the many physicians who help provide these benefits. These benefits must be maximized, but the increasing complexity of treatment, physicians' time, and the other health-care system costs of tobacco-induced disease must be considered when society looks at the benefits of further investment in smoking prevention and cessation. This is particularly poignant in light of the need for physicians, and the health-care system as a whole, to respond effectively to growing pressure from non-tobacco risk factors, such as the increasing aging of the population, and the evolution of other chronic disease factors.

As seen earlier, governments have acted to address tobacco use, but physicians wonder: Has government's response to date been proportional to the harm caused by the industry's products? Have proven and available statutory, enforcement, fiscal and other tools been fully utilized to address this problem?

IV. Society's Response to the Ongoing Tobacco Epidemic: Proportionate or Negligent?

Until the late 1990s, tobacco addiction was thought of primarily as a health issue: efforts to reduce it concentrated on the many disease consequences of addiction, and strategies to address it were framed in terms of messages to "smokers" and the practice of "smoking." Little mention was made of the industry behind the products that are causing such damage.

With the release of large volumes of internal tobacco industry documents resulting from the State of Minnesota's 1998 settlement with the U.S. tobacco industry, and subsequent related litigation by the other 49 U.S. states, North Americans began to understand the true nature and scope of the industry's practices over many decades.

Some of these documents originated with the Canadian industry, and showed clear evidence of manipulation of governments, consumers and research, marketing to young people, and other dishonest and deceptive practices in the service of marketing their products.

Current litigation proposed against the industry by the government of Ontario and other provinces could recoup tens of billions of dollars in health-care costs that have been incurred across the country. It is unclear whether the industry will succeed in passing on the cost of any future outcome of this litigation to its addicted clients through future price increases.

Rather than remaining static in the face of a changing environment, the tobacco industry itself is evolving:

- Cigarette production in Canada is no longer driven solely by a few multinationals and their Canadian subsidiaries. As noted earlier, manufacturing facilities located in Ontario and elsewhere fuel the current contraband epidemic, which in turn undermines both government revenue intake and effective tobacco control policy.
- A notable new combustible is the superslim cigarette, about one-third of the size of a regular cigarette but with the same nicotine level. Sold in packs of 20 also one-third the size of regular packs, superslims are designed and packaged to appeal to younger women.
- While the traditional industry continues to rely on combustible products, primarily cigarettes, newer combustible products, such as rolling papers made of tobacco with added flavourings (the latter are to be banned under federal legislation later this year), and imported waterpipe tobacco used in hookah bars throughout Ontario, are appearing (note: a hookah bar is a place to smoke flavoured tobacco from a smoking device called a hookah). Waterpipe tobacco, sometimes called shisha tobacco, is of particular concern due to the misperception that smoke from a hookah is somehow "safer" because it passes through water prior to

inhalation and is therefore less toxic. Emerging research shows the opposite to be the case.[33]

- Beyond combustible products, various forms of smokeless tobacco, including flavoured chewing tobaccos, moist snuff and snus (a ground, spit-free product in pouches the size of tea bags, are now being test marketed by Imperial Tobacco in two Canadian municipalities), testify to the industry's efforts to find new consumers for new products. Other smokeless products currently being test marketed or investigated include tobacco-based lozenges and other candy-like products.

The industry's ongoing development of new nicotine delivery formats is not surprising given its long-standing recognition that, in the words of former U.S. tobacco giant Brown & Williamson, "Nicotine is addictive. We are, then, in the business of selling nicotine — an addictive drug effective in the release of stress mechanisms."[34] This statement dates from 1963.

How should our society address these continuing challenges? If a physician diagnoses a disease in a patient, there are practice obligations and medical codes of conduct. He or she is obligated to provide all available and useful treatments to that patient as soon as possible. Physicians are often frustrated that similar standards of response are not applied to policy-makers and their approach to this societal illness.

There is massive and long-standing evidence about the harm done by tobacco industry products. Various governments have taken some steps to reduce this harm. Nevertheless, some of the most effective and necessary steps, such as a comprehensive cessation system supported by universal availability of stop-smoking medications, remain at the discussion stage. Despite evidence that contraband tobacco is increasingly accessed by young people, while undermining government revenues and existing tobacco control programs, there are few effective controls on its manufacture and distribution.

When the diagnosis of harm is so apparent, should governments not be held to the same standard as physicians?

Governments have not deployed all available and useful remedies in the face of the catastrophic impact of the tobacco industry's products. Even with commendable work done in Ontario and other jurisdictions, the governmental response to tobacco is not yet proportionate to the harm caused by this industry and its products. The tobacco fight is sadly far from over.

V. Conclusion and Recommendations

As physicians, we view the following as high-priority remedies, to be enacted without delay:

- A comprehensive contraband control strategy should be put in place immediately. Given the apparent inability of governments to require the closure of unlicensed cigarette manufacturers, appropriate sanctions should be applied immediately to suppliers of raw materials to unlicensed manufacturers of tobacco products, and to all those in possession of contraband.
- The government of Ontario must begin the process of drastically reducing the thousands of retail tobacco outlets across Ontario.
- A comprehensive, evidence-based, provincewide cessation system, within which anyone addicted to tobacco industry products who wishes to begin the cessation process can access appropriate assistance, including no-cost cessation medications, appropriate counseling, group therapy, and any other assistance shown to be effective by research.
- A moratorium on the sale of new tobacco products.

As we have seen, tobacco control in Ontario today has two faces. One is characterized by smoke-free spaces, retail and marketing controls, youth-focused initiatives, and some progress on smoking cessation. The other face of the tobacco scourge shows itself in proliferating supplies of contraband product, increasing numbers of both new combustible and smokeless products, continuing struggles of those addicted to find help breaking their addiction, and widespread and easy retail access to "legal" products.

The same duality characterizes the medical sector: physicians have many more tools at their disposal to ease the suffering of those afflicted with tobacco-induced illness, and a broader array of cessation tools, including medications — but at an increasing cost in terms of complexity, treatment dollars, and demands on medical personnel.

Our society must not continue to tolerate this. Our health-care system can no longer afford it, our patients do not deserve it, and we are well-supplied with the tools and knowledge necessary to make further drastic reductions in this entirely preventable health catastrophe. Whether we do so will depend in part on the courage of governments, the determination of health professionals and their non-governmental partners, and on a clear determination of society at large to end the cost and suffering caused by the tobacco industry.

Footnote

a. About the terminology used in this paper: Discussion of tobacco industry products usually refers to "smoking" and "smokers." In our view, "addiction" to "tobacco industry products" more accurately describes the status of individuals addicted to nicotine, and we use these terms often and our text reflects an effort to correct misleading terminology. The tobacco industry commonly refers to its products as "legal," and their use as a matter of "adult choice." Choice is at best a temporary and early-stage behaviour in the process of addiction to nicotine. Statements by industry employees over the years make this case best. In 1980, an employee of British American Tobacco (the parent company of Canada's Imperial Tobacco Ltd.) noted that "it has

been suggested that cigarette smoking is the most addictive of habits — that nicotine is the most addictive drug. Certainly large numbers of people will continue to smoke because they are unable to give it up. If they could, they would do so. They can no longer be said to make an adult choice." (Green SJ. Transcript of note by Dr. S.J. Green. 1980 Jan 1. Document Number 1192.03. Available from: http://legacy.library.ucsf.edu/tid/wdd72d00. Accessed: 2010 Mar 23).

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6. Ibid.
7. Ibid.
8. Ibid.
9. Statistics Canada. Canadian community health survey. Tables 105-0027 and 105-0501 — Health indicator profile, annual estimates, by age group and sex, Canada, provinces, territories, health regions (2008 boundaries) and peer groups, occasional, CANSIM (database).
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