Tobacco Prevention and Control in Dental Practice: The Future

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Abstract: Tobacco use adversely affects oral health and dental care. Globally, the health consequences of tobacco use are worsening, particularly those caused by cigarette smoking. Concerned government and nongovernmental organizations are attempting to contain the transnational tobacco companies' promotion of tobacco use and its disregard for the serious health consequences. Dependence prevents most tobacco users from easily breaking free from their high-risk behavior. Evidence-based clinical treatment methods that substantially increase quit rates are available in the Public Health Service clinical practice guideline, *Treating Tobacco Use and Dependence*. Guideline recommendations are as useful to dental clinicians as to other health care disciplines. Dental educators have a strategic role in ensuring that clinicians are well informed and are skilled in and committed to providing tobacco prevention and cessation services to their patients. Dental organizations must identify and overcome perceived and real clinician and practice barriers to adopting essential cessation services. The dental profession is in an excellent position to play a major role in several emerging issues, such as helping the public and policymakers understand the chronic nature of tobacco dependence and supporting cessation services for all people, particularly pregnant women and youths. Such messages should be presented in terms that resonate with the public because tobacco industry activities and products continue to undermine well-being, the health economy, and individual self-directed behavior of choice.

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Visions of the future must be built on a firm grasp of past and present realities or else they risk becoming illusions and dreams. Leaders in learned professions characteristically seek out issues of rising philosophical importance, so as to be appropriately positioned as opportunities arise. Rewards come to those who recognize substantive issues and are quick to develop new paradigms, form networks, and gain experience in emerging subjects. As once stated by management consultant Peter F. Drucker, “Opportunity comes with the gentle breeze, not the tempest.”

**Tobacco: A Significant Issue**

The prevention and control of tobacco use is an emerging issue of global significance and of central importance to oral health and dental care. It could become one of the most important oral health issues of the twenty-first century. Tobacco prevention and control are important because reducing tobacco use is essential to preventing and treating many oral diseases. Involvement with global tobacco-free initiatives enables the dental profession to keep abreast of rapidly developing scientific advances in tobacco-related patient care and to remain in step with growing public antipathy toward the tobacco industry.

At the dawn of the twentieth century, cigarette smoking became the dominant form of tobacco use. During the past quarter of a century, cigarettes have become carefully engineered products designed to produce a rapid (seven- to ten-second) nicotine “hit” in the brain. The ability to quickly self-regulate each dose, puff by puff, coupled with easy handling characteristics, have made cigarettes the most popular means of using tobacco. In 1998 there were 1.1 billion smokers; by 2025 there may be 1.6 billion. This trend portends an emerging global public health disaster. Why use a product that kills when used as intended? Illusions promote initiation; addiction sustains it. Tobacco use escalates to dependence among a greater proportion of cigarette users than among users of other addictive drugs. Individuals with co-drug dependencies report that cigarettes are the most difficult drug to give up.

Although no form of tobacco use is safe, cigarette smoking has become the most lethal product. One-half of regular cigarette smokers will die of a tobacco-related disease. One-third will die prematurely, losing, on average, two decades of life compared with individuals who quit or never smoked.
Globally, the current annual toll of 4 million tobacco-related deaths is expected to rise to more than 8.4 million by 2020.10 By that date, tobacco deaths are expected to account for one in six deaths from all causes and to become the leading cause of death. Smoking reduces quality of life by increasing the duration and intensity of transient illnesses: impairing senses, physical performance, and the will to act, and reducing disposable income. Societal costs abound. In the United States, $46 billion in gross sales of tobacco (1995) lead to an estimated $130 billion in direct (e.g., medical) and indirect (e.g., fire, lost productivity) economic losses.11,12 However, grief, pain, functional impairment, and other human costs are not so easily translated into economic terms.

Although many diseases afflict humankind, most are not the result of human intent. The tobacco industry promotes products that carry huge risks of injury and death. However, the tobacco industry is highly profitable because it shields itself from the cost of the damage that results from tobacco use. Since the early twentieth century, the industry has managed to exempt itself from nearly every law designed to protect the public, such as the U.S. Food, Drug, and Cosmetic Act, the Consumer Product Safety Act, the Toxic Substance Control Act, the Hazardous Substance Act, and the Controlled Substance Act. As a consequence, more than 430,000 individuals in the United States die each year from tobacco-related causes.13,14 Nevertheless, the industry continues to vigorously seek immunity from any remaining avenues of regulatory and litigation remedy available to the public.

Public perceptions about tobacco differ widely from the realities of personal risk, social harm, and industry practices. Cigarette smokers do not perceive themselves at special risk.15 This perception is due, in part, to massive, widespread, and sustained advertising and promotion by the tobacco industry suggesting that using its products will enhance desired human attributes and that they can be used safely.16 The industry’s implied, but unsupported, illusion that filtered, “low-tar,” “low-nicotine,” “light,” and “mild” cigarettes and smokeless tobacco products are safe encourages many smokers to continue using tobacco long after they would have otherwise quit, or attempted to quit.17

**Tobacco and Oral Health**

Doubts about tobacco’s adverse effects on oral health are evaporating in the face of evidence from a large and growing body of scientific literature that establishes it as an underlying cause of numerous diseases.18-22 For example, smoking is now recognized as a major risk factor for periodontitis and may be responsible for more than half of periodontitis cases among adults in the United States23 (see also the article by Dr. Georgia Johnson in this issue). Pathogens associated with periodontal disease prosper in the mouths of smokers.24 Indeed, in light of current knowledge, mechanical and pharmaceutical treatment of periodontitis without addressing patient smoking is akin to medicating and binding a sliver in the hand but not removing it. The source of the problem must be managed. Treating tobacco use and dependence is as important to success in caring for periodontal disease as are restorative measures for dental caries, and preventing initiation of tobacco use by youths is as fundamental to the prevention of periodontal disease as providing fluoride and sealants are to caries prevention. Tobacco use adversely affects fundamental processes such as wound healing and exacerbates oral disease associated with general medical conditions, such as diabetes and HIV infection. Special oral and dental management may be required because of tobacco-related cardiovascular, respiratory, and other systemic conditions in patients.25

**Tobacco and Behavior**

Increasingly, the ills of humankind are recognized as products of behavior as well as genetics, and of people acting on perceptions dissonant with reality. Advances in understanding brain function are leading to a rekindled interest in behavioral research and a reexamination of social policies.26 During the 1990s, rapid advances occurred in understanding how tobacco use influences behavior during initiation, sustained use, and recovery as well as about its long-term residual effects. Where research once concentrated on tobacco-related diseases and their treat-
ments, emphasis has been shifting toward examining underlying behaviors. Understanding risk profiles helps determine where and how treatment should be focused and which therapies are most effective.

Behavior is a product of fundamental biological processes, underlying perceptions, and experience. Research is moving beyond examination of individual behavior towards a consideration of how it is regulated by biological, psychological, and sociocultural influences. A biobehavioral model has been developed to integrate research now ranging from molecular and cellular to societal levels.27 This model is used by the Tobacco Control Research Branch of the National Cancer Institute as a basis for its comprehensive tobacco research program.28 For example, molecular-cellular research examines how nicotine influences brain receptors and alters neuron structure and function. Behavioral investigations examine the influence of nicotine on cognitive, emotional, and motor functions during the graduation process, dependence, and acute phases of withdrawal and over time. Genetic factors and secondary exposure during fetal and child development are also considered. Sociocultural research examines influences on behavior by such factors as the tobacco industry, social policy, intervention systems, culture, and anthropologic context. Methods ranging from fundamental to translational and clinical research are providing a basis for understanding relationships among biological systems, society, health care delivery systems, health professions, and the public.29 Research on normal behavior and on behaviors under the influence of psychotropic drugs is becoming an increasingly rich source of information for dental education and practice.

Biobehavioral systems that govern behavior, such as desires for water, food, and sex, as well as pleasure reinforcement and pain avoidance, are exquisitely developed because they are essential to the survival of individuals and of the species. Homo sapiens has special abilities to develop foresight and imagination.30-33 Psychoactive substances, with nicotine among the most addictive of them, “hijack” a portion of the structure and functions of the brain associated with reinforcement, learning, and memory.34,35

**Development of Tobacco Cessation Services**

The first Surgeon General’s report, *Smoking and Health*, was released in 1964. Once primary risks were publicized, it might have been expected that smokers would quit and that the tobacco companies would remove their defective products from the market. However, the public did not recognize either the addictive power of tobacco or the tobacco industry’s atrophied sense of social responsibility. The nature and power of nicotine addiction were not widely understood until the 1988 release of the Surgeon General’s report on *Nicotine Addiction*.4 Although the tobacco industry has understood nicotine addiction since at least 1963, findings from industry studies were well concealed and vigorously denied until the late 1990s, when internal documents became available during the course of the litigation discovery process.

Few tobacco-dependent smokers quit without help. About 68 percent of adult smokers want to stop smoking, about 46 percent make an attempt in any given year, and only about 2.5 percent succeed using self-help methods.36,37 The level of desire to quit, the number of attempts to quit, and self-help success rates of high school seniors are all similar to those for adults.38 During the past decade, self-help attempts have increased as the number of treatment options, particularly pharmacotherapy, has increased, but the effect on long-term abstinence is not clear.39 Quitting methods varied widely from the 1960s through the 1980s and were primarily empirical. Long-term success rates, defined as cessation for six months or longer, were low, and the processes of addiction and recovery were poorly understood. Tobacco interventions shifted away from cessation services towards social policy strategies, such as the promotion of clean air laws, measures that would reduce initiation by children and youths, litigation for health and economic harm, law enforcement, and the exposure of tobacco industry tactics. Concurrently, the tobacco industry, through media campaigns, litigation, and legislation, sought to remove barriers to its marketing practices and to shield itself.
from exposure to litigation. The contest continues between those who seek to protect the public’s health and those who seek to serve industry stockholders regardless of health and social consequences.¹

During the 1990s, four major advances occurred for treating tobacco use and dependence:
1. New technology permitted examination of central nervous system development and normal and abnormal brain function. Brain scans, microsensors, radioisotopes, and other sophisticated tools yielded fresh insight about the influence of psychotropic drugs, and particularly nicotine, on perception, emotion, and behavior.
2. At the clinical level, findings from thousands of intervention studies led to the 1996 clinical practice guideline, Smoking Cessation, and the 2000 guideline, Treating Tobacco Use and Dependence. A variety of studies provided information about the dynamics of initiation, graduation, the maintenance of dependence, the acute withdrawal phase, and the modulating influences and relative effectiveness of various behavioral treatment modalities.
3. A variety of pharmacotherapies were found to effectively augment behavioral interventions during the quitting process.
4. Research that once focused on disease outcomes expanded to include the behaviors of tobacco users and then to examine the underlying factors that lead to that behavior. Studies now range from the micro-level (e.g., molecular and cellular), across the individual level (e.g., genetic, perceptual, experiential), to the macro-level (e.g., societal, cultural, environmental).

It is now clear that a significant reduction in tobacco use will not occur if the focus is solely on preventing youth initiation. Equal action is required on two other fronts: one to contain an industry that actively promotes its products, and the other to treat tobacco-dependent individuals. Also, cessation services are a critical time in a three-pronged approach. These approaches require commitment by health care providers; those who educate the providers; researchers who monitor the public’s health and develop intervention tools; and the systems that support health care, professional education, and research.

Evidence-Based Clinical Tobacco Cessation Methods

The 1996 clinical practice guideline Smoking Cessation recommended methods based on more than 3,000 clinical studies in several countries that had been published in peer-reviewed journals over a fifteen-year period. The guideline became the most successful of a long series produced by the Agency for Health Care Policy and Research (now the Agency for Healthcare Research and Quality), and in four years, more than 1 million copies were distributed worldwide. The 1996 guideline focused primarily on individual patient encounters. With rapid advances in the science of tobacco treatment, the 3,000 studies initially available had expanded to more than 6,000 by 1999. The 2000 guideline, Treating Tobacco Use and Dependence, placed an emphasis on regarding tobacco use as a chronic disease. Repeated care is needed to manage the long-term effects and the slow, partial recovery process. Relapse is almost inevitable during recovery, so clinician monitoring and reinforcement are needed just as is done when treating periodontal diseases, diabetes, hypertension, and other conditions requiring sustained management. The new guideline addresses issues commonly confronted, such as triage, care of special patients, and the special conditions, policies, and procedures needed to nurture effective patient cessation and maintenance services. Key recommendations in the current guideline are as follows:
1. Tobacco dependence is a chronic condition that often requires repeated intervention. However, effective treatments exist that can produce long-term or even permanent abstinence.
2. Because effective tobacco dependence treatments are available, every patient who uses tobacco should be offered at least one of these treatments:
   a. Patients willing to try to quit tobacco use should be provided with treatments identified as effective in the guideline.
   b. Patients unwilling to try to quit tobacco use should be provided with brief interventions designed to increase their motivation to quit.
3. It is essential that clinicians and health care delivery systems (including administrators, insurers, and purchasers) institutionalize the consistent identification, documentation, and treatment of every tobacco user seen in a health care setting.
4. Brief tobacco dependence treatment is effective, and every patient who uses tobacco should be offered at least brief treatment.
5. There is a strong dose-response relationship between the intensity of tobacco dependence counseling and its effectiveness. Treatments involving person-to-person contact (via individual, group,
or proactive telephone counseling) are consistently effective, and their effectiveness increases with treatment intensity (i.e., minutes of contact).

6. The following three types of counseling and behavioral therapies were found to be especially effective and should be used with all patients attempting tobacco cessation:
   a. Provision of practical counseling (problem solving/skills training);
   b. Provision of social support as part of treatment (intratreatment support); and
   c. Help in securing social support outside of treatment (extra-treatment social support).

7. Numerous effective pharmacotherapies for smoking cessation now exist. Except in the presence of contraindications, these should be used with all patients attempting to quit smoking.
   a. Five first-line pharmacotherapies were identified that reliably increase long-term smoking abstinence rates: bupropion SR, nicotine gum, nicotine inhaler, nicotine nasal spray, and nicotine patch.
   b. Two second-line pharmacotherapies were identified as efficacious and may be considered by clinicians if first-line pharmacotherapies are not effective: clonidine and nortriptyline.
   c. Over-the-counter nicotine patches are effective relative to placebo, and their use should be encouraged.

8. Tobacco dependence treatments are both clinically effective and cost-effective relative to other medical and disease prevention interventions. As such, insurers and purchasers should make sure that:
   a. All insurance plans include as a reimbursed benefit the counseling and pharmacotherapeutic treatments identified as effective in the guideline; and
   b. Clinicians are reimbursed for providing tobacco dependence treatment just as they are for treating other chronic conditions.

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**Dental Practice Considerations**

All eight of the following guideline recommendations are appropriate to dental practice (see also the article by Dr. Christen in this issue):

1. The guideline did not find significant differences between cessation services provided in dental and medical environments. Methods used, not a clinician’s discipline, are the critical factor.
2. Dentists are obligated to help patients quit because tobacco use is the most common underlying cause of periodontal and many other oral diseases and conditions, apart from the risks to quality of life and to life itself. Evidence is overwhelming that tobacco damages oral health and that clinical cessation methods work in dental practice.
3. Although not specifically addressed in the guideline, professional education institutions, including dental and dental hygiene schools, need to identify tobacco use among all patients. The American Dental Association’s Health History Form includes critical questions about use and patient interest. Many schools integrate such questions into their record keeping systems.
4. The time that the dental team spends with patients usually exceeds that occurring in medical practice. The very brief (i.e., less than three-minute) intervention clinicians should use to advise and assist patients need not be dedicated time but can be easily woven into other diagnostic and treatment services.
5. As with other chronic diseases, repeated assistance is useful. Unlike treatment of other conditions, such support is particularly important to counter incentives by a powerful industry that constantly attempts to encourage previous users to relapse.
6. Patients who quit must learn how to cope with environmental triggers. Resisting the rituals surrounding tobacco use, resisting offers of tobacco and encouraging support from those who live, work, and play with the patient are at least as important as using pharmacotherapies for reducing discomfort associated with withdrawal and recovery. Human interaction with a respected health care provider has a powerful influence and can be tailored to individual patient interests, conditions, and culture. Repeated contacts and a longer duration of contact are often more easily provided in dental practice than in many medical care environments.
7. The Food and Drug Administration (FDA) approves all first-line pharmacotherapies for smoking cessation, so they can be prescribed or, if available on an over-the-counter basis, can be recommended by dentists. Appropriate drug
uses, and the contraindications, are described in the ADA Guide to Dental Therapeutics. Second-line drugs, i.e., those lacking FDA approval for tobacco cessation use, can be prescribed within the scope of medical, but not dental, practice.

8. Compensation for cessation services in dental practice may be by patient payment, by integration into another dental service, or as part of a reimbursement program (see also the article by Dr. Damiano in this issue). Pharmacotherapy should be reinstated as often as needed, that is, as often as relapsing patients are willing to make another attempt to quit, because tobacco dependence is a chronic, relapsing condition that usually requires multiple attempts before long-term abstinence is achieved.

Special Populations

Although most studies have focused on adult cigarette smokers, guideline methods apply to all tobacco users, including male and female, young and old, members of racial and ethnic groups, individuals who are “normal,” and those burdened with psychiatric comorbidities and/or other chemical dependencies. Pharmacotherapies are used with greater caution for youths and pregnant women, depending on the level of tobacco dependence and maturity in the former and with consideration of fetal exposure in the latter. Cessation services are important to reduce the occurrence and severity of many oral conditions related to general health problems.42

Special Guideline Topics

Tobacco dependence can develop from the use of cigars, pipes, bidi, and kretek (clove cigarettes) as well as from cigarettes and unburned forms of tobacco. Recommended treatment methods are similar, regardless of the tobacco product used. Weight gain during the acute stage of withdrawal is a common patient concern, both because the tobacco industry represents it as a condition to be feared and because physiologically transient depressed metabolism and increased hunger signals do promote some weight gain. Weight gain can be managed after the acute phase of withdrawal has passed. With regard to harm reduction, the focus of the clinician should be on the patient becoming tobacco-free. Trading one tobacco product for another (e.g., filtered, “low-tar,” “light,” or “mild” cigarettes; large or small cigars; dry or moist unburned tobacco; tobacco vaporizing devices) is not recommended because no form of tobacco has been found to be safe (see also the article by Dr. Newell Johnson in this issue). Recommending a switch to another form of tobacco reinforces tobacco industry strategies to maintain users on tobacco products.43 FDA-approved drugs for smoking cessation provide a safer means of nicotine administration than any form of tobacco and do not encourage youth initiation, even though they are available over the counter.

Guideline Supplemental Resources

The 1996 guideline quickly became a global “gold standard,” exceeding all others distributed and adopted in numerous countries. A consumer guide published in eight languages complemented this guideline. The 2000 version, Treating Tobacco Use and Dependence, is expected to surpass the earlier version in terms of the quantity distributed and clinician acceptance. (The guideline and the “You Can Quit Smoking Consumer Guide” are available free by calling the Agency for Healthcare Research and Quality at 1-800-358-9295 or by going online to www.ahrq.gov/clinic and by clicking on “Clinical Practice Guidelines.”)

The guideline identifies many important, remaining research questions. Research in progress focuses on cessation services among youths, pregnant women, minority populations, and individuals with special conditions and in varying health care delivery settings. Health care providers may face a variety of conditions that could slow adoption of the cessation methods recommended. Many real and perceived barriers to adoption have been identified.44,45 Barriers to adoption in dental practice should be identified, analyzed, and managed using a combination of research data, education, program management, and provider organizations. Because the field is rapidly expanding, there is a steady stream of journal articles that supplement guideline recommendations—among the most prominent are those from Nicotine and Tobacco Research (http://www.tandf.co.uk) and Tobacco Control (http://www.tobaccocontrol.com).
Dental Educator Issues

When science and social conditions are changing rapidly, shifts in educational curricula may seem to creep. Fortunately, most information emanating from recent advances in understanding human behavior, understanding behavior under the influence of tobacco, tobacco withdrawal and recovery, and the social and public policy arena can be integrated into existing educational programs. Model tobacco-related curricula have been proposed and integrated into dental and dental hygiene school courses. The American Dental Education Association, through a recent grant from the American Legacy Foundation, may have an unprecedented opportunity to facilitate this process.

In just three years, from 1994 to 1997, the percentage of dentists who routinely advised tobacco-using patients to quit increased from 54 to 59 percent. As recently as 1992, dentists were believed to trail physicians by half in encouraging patients to quit, but closer examination of medical practice revealed that most medical advice was given to patients who were under care for overt tobacco-related diseases. Patients presenting for medical care for a non-tobacco-related condition were advised no more than were similar dental patients. Indeed, all health care providers, regardless of discipline or experience, have learned simultaneously because the supporting science and pharmacotherapies have developed rapidly over the past decade.

The new guideline emphasizes that tobacco dependence is a chronic disease. Only now is the medical profession recognizing that tobacco and other addictions need to be treated as such. The dental profession’s experience with tobacco intervention will enable it to grasp essential concepts and to apply insights promoting more effective patient management and better treatment results.

The Future

Tobacco is a rising public issue. The march of science, tobacco control, and litigation builds an ever-stronger case for preventing youth addiction, helping users to quit, and containing the tobacco industry. The dental research, education, and clinical practice communities and their administrators and policymakers have their own reasons for contributing to the reduction of tobacco use.

The dental profession’s future in tobacco control, if not its timetable, is rather clear. A decade ago few dentists identified the tobacco use status of their patients. Few users were advised to quit. Providing help in the dental environment during the quitting process was a rare event. Now, in a majority of dental practices, patient tobacco use status is identified, and users are advised to quit. Some dentists help their patients quit by using recommended clinical practice methods, although most dentists remain reluctant to use FDA-approved pharmacotherapies. In time, comprehensive services will become the norm. However, this is not likely to occur until dental education institutions integrate requisite knowledge, attitudes, and outcome measures into their systems. Educational institutions hold the keys to progress.

In the meantime, research progress is making the process of integration much easier. The 1990s were characterized as the “decade of the brain” as molecular and cellular pathways of this most complex structure became better known. The present decade is characterized as the “decade of behavior” as thought, emotion, perceptions, and behavior become better understood and as findings from basic neuroscience are applied to a host of physical and social ailments. Research on aging, genetics, neural trauma, violent behavior and war, addictions, environmental exposures, fetal and youth development, gender differences, and much more will contribute to a clearer understanding of behavior and the rational management of adverse human conditions. Such advances will be most important to dental teams who monitor developments and benefit from applying evidence-based methods in their practice environment.

Another emerging issue has been the globalization of the contest between the tobacco industry, dedicated to profit, and public health, dedicated to protecting the public’s health and well-being. What began as an individual clinician concern for patients, and was then reinforced by community, state, and national advocates, has in recent years gained an international dimension so as to counter maneuvers by large international tobacco companies. The dental profession is increasingly involved via the FDI World Dental Federation and other international non-governmental organizations that are in partnership with the World Health Organization and government agencies in many countries. In the future, stronger partnerships should help dental practices in the United States and across the globe to effectively reduce tobacco-related diseases and conditions.
potential for involvement by international dental research and education organizations is huge.

Some research issues have yet to find their way into medical and dental practice. For example, the focus on tobacco and reproductive health has centered on pregnant women, fetal health, and infancy. Only recently has evidence shown that smoking during pregnancy may have long-term consequences, such as attention deficit and hyperactivity disorders, even when birth weight is normal. Among children of mothers who smoke during pregnancy, significant cognitive and emotional deficits often exist for years and may be lifelong. The preventable burden of smoking on childrearing and youth behavioral, social, and economic disorders has not been widely recognized, let alone their costs calculated. The dental profession, by gaining access to children, youths, women who are of childbearing age and/or are pregnant, has the potential to position itself as a primary instrument for resolving a scarcely recognized public problem.

Finally, in recent years, there has been a proliferation of public health strategies advocated to reduce tobacco use. Most strategies have been indirect preventive measures. The list grows longer as more evidence supports using cessation services. Revelations about tobacco industry actions against the public, the law, and democratic government have led to an additional long menu of actions. All require political will, but that is difficult to secure when many, often complex, proposals are offered. Proposals must be cast in terms important to the public, for example, in terms of “freedom,” “health and well being,” “justice,” and “economic security.” Tobacco addiction restricts freedom. Tobacco-related diseases undermine well-being. Industry exemptions from consumer protection laws, immunity from accountability, and profits from smuggling defeat justice. Transferring the cost of damages to tobacco users, their families, and their communities erodes economic security. The dental profession can help frame strategies in basic terms so that specific proposals emerge that are meaningful to the public and policymakers. Communicating in culture-specific terms is a skill that is honed in counseling the increasingly diverse racial and ethnic groups represented in dental education institutions and practice. Effective communication with the public is a challenge to dentistry and to all the health professions.

Can the dental profession rise to this significant challenge? Dr. William Foege, who directed the smallpox global eradication program, once said, “One individual who is given a challenge will say, ‘I can’t do that.’ Another will respond, ‘I can.’ Both are right.” Which of these two individuals characterizes the dental profession will determine its future in tobacco prevention and control.

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