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Tobacco: Actual Ethical-Medical Considerations with Tabaquism

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1. Introduction

The Native Americans used the tobacco in many religious ceremonies before the discovery of America in 1492 by Christopher Columbus who took it to Europe. In the middle of the XVI Century tobacco smoking spreads into Spain, France and Portugal, and it received its scientific name “*Nicotiana Tabacum*” in Linneo’s classification.

The tobacco was consumed by the highest European nobility, since it was introduced in England by Raleigh and Drake, and in Portugal by Nicot.

Tobacco consumption spread all over Europe, in spite of the opposition of many people that detested its use and gave arguments to penalize this new addiction, nothing avoided the increasing popularity of tobacco.

In 1882 while Robert Koch found the tuberculous bacillus, Albert Bonsack invented a new device to build up cigarettes. James Duke bought this novel device and the great earnings produced by cigarettes sales, prompted him to give an economical donation to one prestigious University, which in order to honored him, added his name, and since then is known as Duke University.

In 1954 Richard Doll and Bradford Hill published a study showing the relationship between tobacco consumption among British doctors and mortality. This study was determinant to show the relationship between tobacco and mortality.

Tobacco addiction is a serious problem in public health, since its consumption yields many direct and indirect diseases, handicapping many young people in the most productive years of their life.

The use and abuse of this drogue goes against established principles in different international meetings in Bioethics. Although the first established principle is autonomy, that means, a free will about their own existence, it is extremely important that these decisions do not harm a third people, since it is well known the injurious effects of tobacco smoke over passive smokers.

Doctor Ignacio Chavez used to say: “the doctor has a professional duty with the healthy and with the sick, who put all its faith into the doctor”. This concept fits in the Benefit principle, which states that the doctor must benefit the healthy and the sick avoiding or prohibiting tobacco consumption.

Regarding the principle of no – maleficency or do not harm, it is clear that many studies have shown the damage produced by tobacco, thus it is a social duty specifically for doctors to precisely inform all the multiple pathologies produced by tobacco.

In terms of justice in health, that means, that everyone receives what it needs, independently of the social-economical level, we must take in account that all the diseases produced by tobacco consumption alters all the social security budgets all over the world. For instance, in the National Institute of Respiratory Diseases in Mexico, tobacco absorbs an important part of its budget, since it is directed to treat diseases such as chronic bronchitis, lung cancer and lung emphysema, as well as breast and bladder cancer. Regarding the cardiovascular system, 165 people die every day in Mexico due to diseases related with tobacco. Thus, it is not fair that many economical and human resources are dedicated to treat avoidable diseases; since they could be used in other pathologies and mostly in research.

The medical ethics has had an important development in recent years in the daily relationship between the doctor and the patient.

This chapter deals with the ethical act that the specialist doctor must have in front of the different diseases of the respiratory system, that actually are among the leading causes of human morbidity and mortality.

2. Ethics in tobacco industry development

Tobacco production by itself is an activity that generates local to general social damages, from its harvesting to the final consumption. For instance, tobacco workers quality of life was precarious, since they had to live in tobacco plantations and they lacked of elemental amenities; 90% cooked with wood, 57% got pure water for human consumption, 31% lacked of clean water for hand washing, 38% lacked of soap, 23% used river water and 98% did not have a letrinne to defecate. Their working conditions also required agriculture skills in order to learn how to manage and cut tobacco plants, and due to the low income they had to include part or the whole family including two girls for one boy in this job. There were also other risks associated with it, like limited health services access, poor nutrition, analphabetism, monolingual, low income, and lack of basic services.¹

By the year 1900 there were about 743 cigarettes factories, which are basically owned by few families. Since the 90's and under a monopoly scheme, the tobacco industry is characterized by a duopoly. Market control mechanisms characteristic of tobacco industry has its immediate antecedent in the setting of the price in diverse trade markets and in setting the time for harvesting, creating a real need to produce and to sale, generating anxiety in consumer groups, warranting their own regulatory mechanisms.

In 1997, the Mexican tobacco industry gave up the actionary control to two enterprises that practically control the whole world: Phillip Morris and British American Tobacco, which changed the national industry into a subsidiary of these two global industries. The benefits of this acquisition of the Mexican tobacco industry, went into a established market of consumers which warranties the product sale and the acquisition of a new commerce platform out of the taxation in their countries of origin.

¹ Grupo Interinstitucional sobre Estudios en Tabaco. Información relevante para el control del tabaquismo en México. 2003

Tobacco consumption causes more damage than benefits, in spite of that tobacco and cigarettes have a value and consequently generate a great wealth, this is not reflected in social wealthness, by contrary its consumption only generates richness only to tobacco industry.

The consumption market is projected in the future, since its major offer is focused to young people. The tobacco industry is developing commercialization techniques to recruit young consumers, this is the reason of the marketing spots found in sport events, or evoking certain style of way of life, calling attention to success, sexuality and wealthy people, among others. There are several trade marks present in the market, that apparently compete among them. What is behind this is the possibility of acquisition depending on the income or relating the money owned in a determined moment, same as the taste of the consumer.

The national and international tobacco industries know that they own a highly productive business, in spite of the harmful to peoples' health, always getting earnings and no losses at all, everything based on the addictive power of nicotine.

It is evident that restrictive politics in tobacco consumption in order to protect smokers and non smokers health, like increasing the tax of cigarettes package price and developing a contraculture of tobacco consumption will reduce the number of smokers that this industry recruits every day.

In 1942 the "Institute against tobacco danger" was funded in the Jena University of Germany where they carried out, with a high level of methodological sophistication and a high epidemiology knowledge, the first controlled study about the relationship between tobacco and lung cancer, in which they concluded that smoking was closely related to the risk of lung cancer.² There was a serious worry about the damaging effects of tobacco to the health. Dr. Leonard Conti, who was in charge of military sanity in Germany, funded an agency against the use of alcohol and tobacco, promoting healthy activities among young people. In 1939 tobacco was banned among soldiers, and it was also prohibited in the streets, during festivals, etc. Smoking was also forbidden to teachers and for people under 18 years. In 1944 it was forbidden to smoke in public buildings, hospitals, trains and autobuses.³

3. Ethics and tobacco control

In 2003 the WHO headed the Worldwide response to the epidemic of Severe Acute Respiratory Syndrome (SARS) that caused thousands of deaths in few months, identifying the causal agent, the epidemiological transmission characteristics and, establishing the control measures.⁴

Let us imagine that the WHO would not had taken these measures, the lack or absence of support by the scientific community, would had posed a huge problem, the free commerce would have occurred without any caution or procedure in order to avoid the spreading of

² Rose N. *The Politics of Life Itself. Biomedicine, power and subjectivity in the twenty first Century.* Princeton University Press. 2007. pag. 58.

³ Pactor R. *Racial Hygiene: Medicine under the Nazis.* Cambridge, Mass./London; Harvard University Press. 1988. Citado en N. Rose (cita anterior, pag. 58)

⁴ Novotny TE, Carlin D. Ethical and legal aspects of global tobacco control. *Tob. Control* 2005; 14 (Supl. II): ii 26-ii30

the disease. For sure this would have brought conflicts among nations. Fortunately, all the international cooperation and control measures were excellent.

Tobacco is causing an epidemic disease since 500 year ago, and its management has been exaggerated slow causing thousands of deaths. A response based in ethical principles with International collaboration and cooperation among the governments is needed.

Global usage of tobacco and the weight of disease implies a detriment of sovereignty in the countries, since this epidemic goes directly against peoples' health. Public health needs a conscious analysis related to the appearance and reappearance of infectious diseases, the degradation of the environment and bioterrorism.

Tobacco causes diseases in a global perspective. Thus the WHO established the MARCO agreement with around 2000 articles in it, stressing the importance of the inclusion of all the countries in the agreement. The MARCO agreement was signed in May 2003, including México.

In 2030, will have around 10 million deaths by year and 70% will occur in low income countries. These numbers are the origin of International cooperation with very clear ethical and law principles.

4. Global usage

Globalization could be defined in a general sense as conduct of population trough three dimensions: space, time and knowledge.

Spatially, globalization refers to lack of influence in national frontiers, with free movement of articles and persons. In the international commerce it is legal that publicity crosses freely, like internet information and environment pollution. This has economical, political, cultural technological and even health impact, decreasing sovereignty that "depends" on frontiers. This sovereignty effect urges the nations to focus in their frontiers, in health conventions with other governments.⁵

Temporary dimension involves short time to communicate and to travel. This may involve infection diseases or dangerous market products spreading, like tobacco. The globalization redefines the culture, the image and the market demand trough their products and knowledge.

In the case of tobacco, the globalized knowledge forms mental nets around tobacco, that is, tobacco "is synonymous" of modernity, prosperity and occidental values. This creates the image of "global Smoker".

Four companies have 75% of the worldwide market share; Marlboro has 8.4% of worldwide smokers. This success is due to Phillip Morris, an enormous enterprise around the world.

The globalized knowledge is defined as the illegal smuggling by political intervention, anticipating international and government agreements and regulations.

Ethically this globalization about work production, threats nations autonomy and the protection of their citizens. It also violates the principle of no-maleficency due to the use of tobacco which produces potentially deathly diseases, so any tobacco promotion in the commerce has a maleficency effect by itself.

⁵ Novotny TE, Carlin D. Ethical and legal aspects of global tobacco control. *Tob. Control* 2005; 14 (Supl. II): ii 26-ii30

Efforts of transnational tobacco corporations (TTC) distract attention away health issues and they only highlight the economical impact. They emphasize that politics are not directed to children but to adults, which is false. Global usage of tobacco depends on publicity, the usage of image and free commerce. Regulation it is extended trough frontiers with few information and with no contra information. It is clear that justice ethical perspective requires participation of government based on beneficence principle.

The International Court of Human Rights describes standards in order to secure responsibilities and preserve abuses to human rights of private entities. Governments must look for no maleficency from private companies.

Smokers and potential smokers must be very well informed of the risks and damages of smoking. Natural addiction caused by nicotine use and the harm produced in passive smokers must be advised. These dangers and risks are hidden to poor and young people, thus this kind of information is considered to be asymmetric since it avoids a thorough and complete knowledge. This asymmetric information violates justice principle.

The “not safe” advertising for tobacco is not enough for smokers since they have the right to know more about the risks and dangers that tobacco causes in his body. ⁶

5. Mexico's scenario

Actually more people die in the world by tobacco consumption than any other risk factor. At least 20 causes of death and disability have been identified (Table I); these diseases are preventable. This tobacco epidemic has been described in four phases depending on the behavior of some causes called as sentinel, like lung cancer. The first two phases show a high tendency in prevalence of smokers; the third describes a plateau and the last one are related to the countries, after going in the first steps has diminished and maintained this tendency.⁷ Countries like US and most in Europe are in levels III and IV. Developing countries, like Mexico are in the group I and II.⁸

The nocive effects over the health due to tobacco consumption or tobacco fumes exposition are manifested in the mid or long term, this is the reason of the early morbidity and mortality prevalence most of smokers initiate about 20 years old, morbidity and mortality are clearly identified at the age 35 years. Many neoplasias, cerebrovascular and cardiovascular diseases, as well as many chronic respiratory diseases are the main causes of death. The estimated in deaths atribuible to smoke in Mexico are more than 42 000 in the year 2000 representing 11.6% of all causes of death in people over 35 years. Particularly in respiratory diseases attributable to tobacco, it represents 59% within this group; as well as 39% of neoplasias, 17% of cardiovascular deaths and 15% of cerebrovascular vascular diseases, that could be associated to tobacco consumption.⁹ Table 2.

⁶ Kozlowski LT, Edwards BQ. “Not safe” is not enough: smokers have a right to know more than there is no safe tobacco product. *Tob Control* 2005 14 (suppl II) 113-117.

⁷ Corrao MA, Guindon GE, Cokinides V, Sharma N. Building the evidence base for global tobacco control. *Bull World Health Orgn*, 2000;78(7):884-90.

⁸ Grupo Interinstitucional sobre Estudios en Tabaco. Información relevante para el control del tabaquismo en México. 2003 p 12-13.

⁹ Grupo Interinstitucional sobre Estudios en Tabaco. Información relevante para el control del tabaquismo en México. 2003 p 12-13.

1 C 00 - C 14	Lipp, mouth and pharynx tumors
2 C 15	Esophageal tumor
3 C 16	Stomach tumor
4 C 18 – C 21	Colon and rectum tumor
5 C 25	Pancreatic tumor
6 C 32	Larynx tumor
7 C 33 – C34	Trachea, bronchial and lung tumors
8 C 53	Cervical uterine tumor
9 C 64 –C 65	Kidney and kidney pelvis tumors
10 C 67	Urinary bladder tumor
11 C 92	Acute mieloyde leukemia
12 I 10 –I 13	Hypertension
13 I 20 - I 25	Cardiac ischemic diseases
14 I 00 - I 09 I 26 - I 51	Other heart diseases
15 I 60 - I 69	Cerebrovascular diseases
16 I 70	Atherosclerosis
17 I 71	Aortic Aneurism
18 I 72 - I 78	Other circulatory system diseases
19 J 10 - J 18	Pneumonia e Influenzae
20 J 40 - J 43	Bronchitis, emphysema
21 J 44	Other chronic obstructive pulmonary diseases

Source: Interinstitutional Group in Tobacco Studies. Relevant information for tobacco control in Mexico. 2003

Table 1. Atribuible diseases to tobacco consumption and causes of death.Tenth revision of the International Disease Clasification

Expected deaths atribuible to tobacco consumption					
Population Year 2000	Neoplasias	Cardio vascular	Cerebro vascular	Respiratory	Total
35	220	297	143	96	756
40	349	461	208	141	1159
45	484	667	310	190	1652
50	739	958	450	262	2410
55	936	1319	635	496	3386
60	1315	1852	794	825	4786
65	1514	1076	295	1865	4817
70	1582	1076	295	1865	4817
75	1482	1244	352	2481	5559
80	980	1146	316	2507	4949
85	897	2350	588	5314	9149
	10499	12291	14321	15476	42588
Deaths 35+	2.9%	3.3%	1.2%	4.2	11.6%
Deaths in causes group	39%	17%	15%	59%4	

Source: Interinstitutional Group in Tobacco Studies. Relevant information for tobacco control in Mexico. 2003

Table 2. Mortality due to tobacco consumption in México,Grouped by five years, 2000

There are about 17 million smokers in Mexico, and nearby 60 000 people die in one year due to diseases related to tobacco. This represents around 165 daily deaths which 38%results from ischemic heart disease, 29% from emphysema, chronic bronchitis and chronic obstructive pulmonary disease, 23% from cerebrovascular disease and 10% from lung, bronchial and tracheal cancer¹⁰.

In 2002, The National Investigation for Addictions found that 23.5% of the Mexican population among 12 and 65 years, is a smoker, 17.4% have smoked importantly and more than half (59.1%) manifested never have smoked, 25.6% was a passive smoker (that means around 17 860 537 persons). On the other hand 1.4%, was identified as a dependant smoker, which represents more than a million requiring specialized attention.¹¹

In several studies, tobacco consumption seems to be the initial drug-to-drug consumption (this risk is incremented over 13 times). In Mexico, this has been also documented;

¹⁰ Kuri-Morales PA, González-Roldán JF, Hoy MJ, Cortés-Ramírez M. Epidemiología del tabaquismo en México. Salud Publica Mex 2006;48 supl I:S91-S98.

¹¹ Hernández-Ávila M, Rodríguez-Ajenjo CJ, García-Handal KM, Ibáñez-Hernández NA, Martínez-Ruiz MJ. Perspectivas para el control del tabaquismo en México: reflexiones sobre las políticas actuales y acciones futuras. Salud Pública Mex 2007;49 supl 2:S302-S311

addressing that there is a direct relationship among tobacco and alcohol, and drug consumption in teenagers.¹²

Recently the Health Ministry and the Federal Government implemented the National Program against Tobacco (2001- 2006)¹³. This program is present in the whole states of the country and has juridical instruments or elements. In 2002, 130 000 elementary and secondary schools were declared “free of tobacco smoke”. In 2007 more than 532 buildings are recognized as “free of tobacco smoke”. Also, since 1998 the OFICIAL MEXICAN NORM 168-SSA1-1998 about medical records inscribes the obligation of asking specifically on tobacco consumption. A convention was signed with the Mexican General Medical Association in order to receive specific training for counseling. In the beginning of 2001 there were 36 tobacco clinics, in 2007 there are 336, they give to patients pharmacological treatment and psychological support.¹⁴

From the year 2000 there have been several federal political, legislative and administrative measures. In 2005 the advertising legend against tobacco should be equivalent to 50% of the contra face of the cigarette box area. Regarding taxes imposition, they were increased 140% in 2007, 150% in 2008 and 160% till now days.

In May 2004 the Mexican government announced the agreement with the tobacco industry in regards of the industry contributions and tobacco control measures to the Seguro Popular de Salud, a program to people without health insurance.¹⁵ Mexico agreed measures to tobacco control; these controls are less restrictive than those in the Framework Convention on Tobacco Control, which Mexico has ratified. Although measures to restrict tobacco consumption are taken, due to the laxitude in tobacco control, in Mexico it is difficult to get strict control, other countries could be discouraged due to Mexico’s example.¹⁶

It has been calculated that in 2008 the cost for medical attention in diseases related to tobacco consumption were around 5,700 millions USD. This estimation is based on the total expense in health and supposes treatment costs related to tobacco represent 10% of the total cost in medical attention.

In the National Institute of Respiratory Diseases (INER), the 2009 cost for lung cancer treatment rised to \$ 2,974,638.20 USD, representing nearby 4 - 5% of the Institute’s budget. The INER is a public institution, thus the subsidy for patients is nearby 93.11%. Most of the cost (63.28%) corresponds to indirect costs, meaning that drugs and bed-day are part of this indirect cost. From the total direct cost is 36.72%, meaning for this human resources, medicine, laboratory and image studies. The cost by day for lung cancer is around \$2,465 USD, been expensive for the majority going into this Institute. Table 3.

¹² Medina-Mora ME, Peña-Corona MP, Cravioto P, Villatoro J, Kuri P. Del tabaco al uso de otras drogas: ¿el uso temprano de tabaco aumenta la probabilidad de usar otras drogas? *Salud Publica Mex* 2002;44 supl 1: S109-S115

¹³ Programa Nacional contra las Adicciones. Programa contra el Tabaquismo. Secretaría de Salud/Consejo Nacional contra las Adicciones. México, 2000.

¹⁴ Hernández-Ávila M, Rodríguez-Ajenjo CJ, García-Handal KM, Ibáñez-Hernández NA, Martínez-Ruiz MJ. Perspectivas para el control del tabaquismo en México: reflexiones sobre las políticas actuales y acciones futuras. *Salud Publica Mex* 2007;49 supl 2:S302-S311

¹⁵ Presidencia de la República Aportará la industria tabacalera 4 millones de pesos para el sistema de salud de México. 2004. www.presidencia.gob.mx/buen/?contenido=8281&pagina=151(accesed 29 marzo 2011)

¹⁶ Samet J., Wipfli H, Perez-Padilla R and Yach D. Mexico and the tobacco industry: doing the wrong thing for the right reason? *BMJ* 2006;332:353-354.

Malignant Tumors 2009.				
Expenses in Medical Services	Expenses in Stage	Expenses in Medicines	Expenses in Materials and Medical Incomes	Total expenses in hospitalized patients by malignant tumor
1,241,697.80	1,422,178.80	217,621.04	93,144.45	2,974,638.20

Source: Based in Information by Biostatistics and Informatic Departments. Cost Unit. National Institute of Respiratory Diseases.

In Mexico, the cigarette consumption has diminished as the price has been increased.¹⁷ Taxes to cigarretes in Mexico are low compared with the international standard. Although there are at least two taxes, one special directed to consumption called ‘Impuesto Especial sobre Producción y Servicios’ (IEPS) special tax for production and services and the VAT which applies to all services. The IEPS is composed by ad valorem tax which is 160% over the price sold to the minorist. This specific component will be increased step by step: 0.80, 1.20, 1.60 and 2.00 Mexican Pesos per 20 cigarettes package in 2010, 2011, 2012 y 2013, respectively. This tax does not adjust to inflation. The VAT augmented from 15% to 62.8% of the final price by the end of 2010. Table 4.

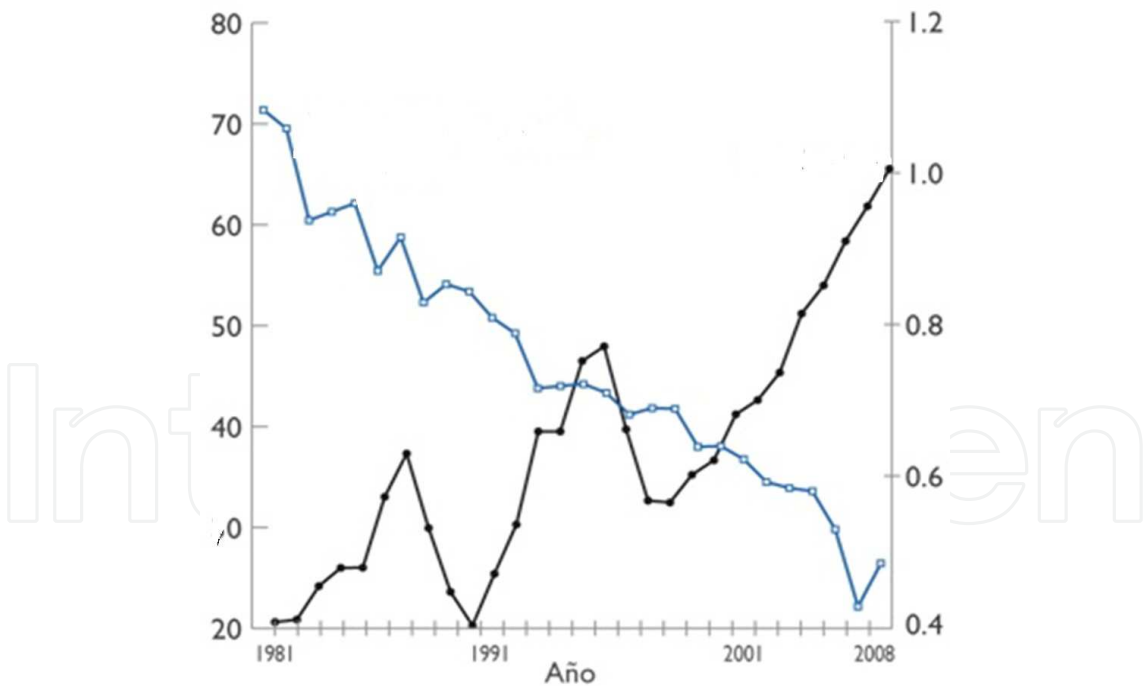


Table 4. Cigarette consume and real price (1981-2008)

¹⁷ Waters H, Saénz de Miera B, Ross H, Reynales Shigematsu LM. *La economía del tabaco y los impuestos al tabaco en México*, This is part of the informs about economic aspects financed by Bloomberg Philanthropies y por Bill and Melinda Gates Foundation as parto of Iniciativa Bloomberg to Reduce tobacco consumme.

6. The new challenge

The free market also fosters the proliferation of industries, such as tobacco, food, and chemicals, which externalize costs to maximize profits, seek to unduly influence research by paying experts and universities, and attempt to control the media and regulatory agencies. The most vulnerable to the cumulative harm of these tactics are the children, the poor, the sick, and the least educated.

The free market can harm health and health care. The corporate obligation to increase profits and ensure a return to shareholders affects public health. Such excesses of capitalism pose formidable challenges to social justice and public health. The recognition of the health risks entailed by corporation-controlled markets has important implications for public policy. Reforms are required to limit the power of corporations.¹⁸

The governmental task forces encourage further restrictions of tobacco advertising through voluntary self-regulation by the industry, and not by governmental legislative actions. Further research on tobacco advertising in Japan, such as its influence on juvenile smoking and social norms and the effectiveness of voluntary self-regulation, is required to develop appropriate policies on tobacco advertising control.¹⁹

To keep working in the social and cultural aspects, is essential in order to adequate educational and transformational strategies creating healthier environments implementing new life styles to future generations. Making a difference between well and bad represents one of the threats in education fields, thus a reform in educative curriculum that includes ethics, bioethics and philosophy should be redirectioned.

It is quite clear that there is an increasing tendency of tobacco consumption among women not only in Mexico but also internationally. Advertising and a lack of education regarding tobacco damage are part of the scenario in young people living apparently free but in disorder regarding conducts and happiness perception as they assume it should be understood.

If a government does not respond to necessities of population regarding to health, it is and will be questionable about the capacity to manage even to maintain the social system.²⁰

It has been described how enterprises calculate to invest in to those countries where public and government awareness requires exemption related to taxes.²¹ The Nuffield Council on Bioethics set out a proposal to capture the best of the libertarian and paternalistic approaches, in what it calls the 'stewardship model'. This model cares for the vulnerable, autonomy and consent. The state most paid for several interventions among them: infectious diseases, obesity, alcohol, tobacco and fluorination of water supplies. The state has a duty to look after the health of everyone, and sometimes that means guiding or restricting people's choices.²²

¹⁸ Brezis M, Wiist WH. Vulnerability of health to market forces. *Med Care*. 2011 Mar;49(3):232-9.

¹⁹ NippoSone T. Effects of tobacco advertising regulations in various countries *Koshu Eisei Zasshi*. 1995 Dec;42(12):1017-28.

²⁰ Moreno García D, Cantú Martínez PC. Documento de trabajo:. Gobierno y tabaco. Centro Universitario para la Prevención de la Drogadicción, Facultad de Salud Pública y Nutrición, Universidad Autónoma de Nuevo León (México), Coordinación General de Investigación, Facultad de Salud Pública y Nutrición, Universidad Autónoma de Nuevo León (México)

²¹ Pollock D. Forty years on: a war to recognise and win. How the tobacco industry has survived the revelations on smoking and health. *Br Med Bull*. 1996 Jan;52(1):174-82.

²² Calman K. Beyond the 'nanny state': stewardship and public health. *Public Health*. 2009 Jan;123(1):e6-e10. Epub 2009 Jan 9.

Public health efforts to promote tobacco control are not easily performed. There is a need to interpretation since consumers and policymakers have different points of view. Tobacco industry seems to protect individual rights and that the public health community is trying to eliminate those rights. Reframing public health efforts in accordance with core ethical principles, the public health community can create more positive messages. A public health ethics.

A Framework is proposed to examine how the application of the principles can influence the tobacco control movement. Through the increased use of ethics in tobacco control, the public health community may be better positioned to claim the high road as the protector of the public's interests.

It is well known that tobacco is dangerous for health. Nevertheless is not well identified as causing economical disaster too. Consumers and producers obtain both benefits as immediate pleasure and earnings in terms of market, but they are in a lower level in front of the elevate cost of diseases and deaths caused by tobacco.

The increase of incidence and survival rates, should take consciousness that pulmonary diseases are a huge epidemic, and not only that but being able to have solutions at the health services and also into the governmental level directed to prevent and control them.

The patient with lung cancer is responsible for a defective act, the disease is not influencing to decide the well or bad, this means he is not able to dilucidate or to understand the results of his actions in order to direct his conduct. Family also influence the doctor in order to judge patient attitude and puts him in prison.²³

7. Conclusion

Lately, the physician-patient relationship has changed, - The doctor used to be seen in a paternalistic view in front of the patient, that means that physician had the first and the last word. The Family often accepted his verdict. The sick person did not have voice neither vote, his role was passive, they only trust in the physician, he used to be at the head of the patient bed.²⁴

An Ethical controversy is also present when evaluating a patient for transplantation. Some professionals refuse to transplant if the patient smokes or is obese. For example, tobacco use has been linked to poor graft survival, patient survival, complications, and morbidity, whereas tobacco cessation has been associated with improved patient and graft survival. Over time, transplant professionals increasingly believe that tobacco use should be a relative contraindication to organ allocation. That belief seems to be strengthened after providing education on pertinent evidence linking tobacco use to medical consequences in both the general and the transplanted populations.²⁵

²³ Ortiz Martínez A, González Martín A, Lorenzo Rubio JL, Hernández Navarro M, Cabrera Cabrera C. El cáncer de pulmón: Algunos aspectos sociales y bioético. *Rev Cub Hig Epidemiol*. 1996; 34 (3):81-90.

²⁴ Alfaro Ramos L, Magaña Izquierdo M. Administración de riesgos: Medicina Preventiva para médicos y organizaciones de salud. *Rev Nal Enf Resp Mex* 2009; 22(2):137-143.

²⁵ Ehlers SL. Ethical analysis and consideration of health behaviors in organ allocation: focus on tobacco use. *Transplant Rev (Orlando)*. 2008 Jul;22(3):171-7. Epub 2008 Apr 23.

The sick person did not have neither voice nor vote, his role was passive, he trust on person who had the truth, the one having studied to cure, he trust on his experience, and even more if he was the family's doctor, the years knowing each other, doctor was a member of the family. With all these warranties who could be afraid?

To this docility and trust, the galenian corresponded with an exquisite attitude to the patient and his family, acting with intention out of question, everything but the welfare of his patient, even if it was necessary, he paid with part of his personal belongings in order to satisfy his patient needs of health. With this in mind, things would not appear to change.

Social value crisis also affected medical practice. The introduction of marketing also was part of the doctor's tool. The terms now used by medicine professionals are similar to the business people, they talk about management, quality, risk management, etc., also the term patient is substituted by client, satisfaction, that substitute the term used in our country as "grateful patient". The excess of publicity exhibits the merits of the professional ensuring zero risks, this seems to be a generalized conduct in order to that doctors do not seem to be antique. As much as experienced doctor shows, as much as the tariff rises also, there is no space for charity used before to indigents.

What is at least in-patient and his family is the survival instinct and have learn to make his rights value, not allowing to damage his patrimony. Even more, they would not permit to be treated as guinea pig, not to be victims of complicated laboratory exams for simple parasites, they also are not to be in the therapeutic obstination for living few days with poor quality of life. Patients with educational, cultural and over all economic possibilities, look for an advocate, who discovered a new desire fountain

As a medical doctor it is difficult to recognize this picture. On the other hand it is tranquilizing that fortunately must doctors act following the Hipocratic oath with fidelity. These situations have motivated two attitudes: one positive for the patient and one defensive for the doctor. These are the informed consent and the insurance policy against mal praxis. With the informed consent the sick person can decide his opportunity to choose the examinations or treatments, without losing autonomy.²⁶ Papers to fill up in augment, attention seems to be tedious but with an explanation gives support and tranquility to both parts. Insurance contributes to tranquility, that means, that is not matter of the great knowledge in science the doctor has, he is human and fallible, he can also be protected from bad intentions.

All seems to be concluded but the patient-doctor relationship is not finished. We have to rescue our image. New generations of pneumologist need to include into their school curriculum matters regarding humanism, and all signatures by ethics, deontology and bioethics. But not only that, they need to observe and absorb from their professors who have to show their values and virtues as they teach, as they cure, as they accompany.

If government loses credibility by society, the professionals in public health should not be worried about drugs prevention if the trend to global economy is legalize them, their function should be to demand security in health that includes to reinsert ill people into society, with perfect knowledge of what is well or wrong without recruiting them, prohibiting and lacking freedom

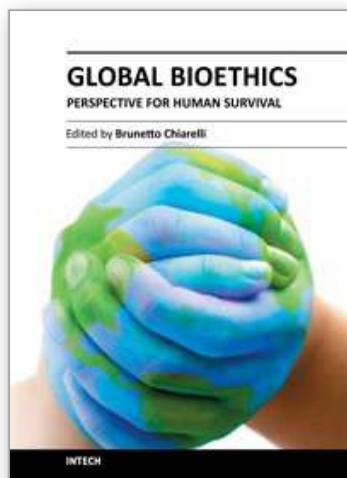
²⁶ Alfaro Ramos L, Magaña Izquierdo M. Realidades conceptuales del consentimiento informado para la seguridad del médico y del paciente. *Rev Nal Enf Resp Mex* 2008; 21(3):213-220.

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Two new factor have been added to the ideological change in the second half of the past century: the “ecological impact” of humankind on the environment due to the population increase; and the “ innovative impact of science, first with atomic physics, which introduced the scission of the fundamental unit of matter, the atom, and then witch molecular biology, which led to the decoding of genetic information and intervention of biological engineering that annihilate our concepts of individual and species as fundamental units in biology. This stage of fundamental rethinking is however overshadowed by the threat of ecological disaster and catastrophic population increase, which not only impose limits to development, but undermine the very survival of Humankind. The future survival our species in fact depends on the interaction between its reproductive characteristics and the productivity of the territory, which, even if increased by the intellectual capability of the human brain, has intrinsically limits. The adaptive choices (which are also biotechnological and biomedical) of the interaction between human population and the natural ambience is the conceptual basis of the new discipline “Global Bioethics”.

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