Guest Editorial

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COPD—A Call to Action for Federal Practitioners

Tobacco use is the leading preventable cause of premature death in the United States. It is estimated that, directly or indirectly, tobacco is responsible for more than 400,000 deaths (nearly 20% of total deaths) annually in the United States. Chronic obstructive pulmonary disease (COPD) comprises approximately 60,000 of these deaths.[1] COPD is currently the fourth leading cause of death in the United States, but will rank as the third leading cause by the year 2020.[2] Because 90% of COPD is due to the inhalation of smoke from burning tobacco products, most cases of COPD are preventable.[3]

Recently, the Global Initiative for Obstructive Lung Disease (GOLD) issued a new classification of COPD severity.[4] Subsequently, the American Thoracic Society (ATS) modified its criteria for the classification of COPD severity.[5] The result of the new classification criteria is an earlier diagnosis of COPD and, thereby, an opportunity for early intervention. Unfortunately, individuals with COPD typically do not become symptomatic until they have lost a significant amount of lung function. Since COPD usually does not become symptomatic until later in life, many individuals affected by this disease believe the symptoms they are experiencing are normal consequences of aging. Because simple spirometers are inexpensive, easy to operate, and can achieve a high degree of reliability, their use as a diagnostic tool is advocated for all individuals at risk for COPD.

Currently the number of smokers in the VA patient population is significantly higher than that in the general U.S. population. Thirty-three percent of veterans smoke compared with 21% of the general population.[6] Although the exact percentage of veterans who have COPD is not known, the incidence is expected to be higher than the general population because of the higher rate of smoking and the older age of the veteran population. Therefore, COPD is of particular concern to health care providers working in the federal health care system. The article by Drs. Demirjian and Soo Hoo in this issue of *Federal Practitioner* is both timely and salient.[7]

Health care providers in the DoD are also stakeholders in the fight against COPD. In 1980, 51% of military personnel smoked. By 1998, that number had decreased to less than 30%. However, from 1998 to 2005, the rate of cigarette smoking had increased to more than 32%. Interestingly, there is a variation among the uniformed services. The percent of smokers in the army is 32%, navy 32.4%, air force 23.3%, and marines 36.3%. Many of these service members began smoking while in the military.[8] Although the DoD has a stated policy advocating a smoke-free military, no date has been specified for the military to become smoke-free.

In 2009, approximately 25% of Native Americans smoked cigarettes. American Indians and Alaska Natives are, overall, more likely than any other racial/ethnic subgroup to be current smokers. According to the National Health Interview Survey (NHIS) of adults 18 years of age and older, 23.2% of American Indians and Alaska Natives smoke, compared with 22.1% of whites, 21.3% of African Americans, 14.5% of Hispanics, and 12% of Asian Americans. Smoking rates vary considerably from one tribe to another.[9] In 2005, 14% of South West tribal members were smokers compared with a 50% smoking rate among Northern Plains tribal members.[10] According to the 2009 NHIS, American Indian and Alaska Native men have the highest smoking prevalence among all racial/ethnic subgroups at 29.7%. The subgroup with the next highest smoking rate is white men at 24.5%.

American Indian and Alaska Native women smoke at a rate of 22.4%. Smoking prevalence for white women, who have the next highest smoking rate, is 18.3%.[9] In addition, 18.2% of American Indian women smoked during their pregnancy, compared with 13.8% of white women.[11] The health care disparity has been growing over time. Since 1978, the prevalence of cigarette smoking in women of reproductive age (18 to 44 years) has declined in every subgroup of the American population except among American Indian and Alaska Native women.[12]

This information should alert health care providers to the significant impact that cigarette smoking and COPD have on the federal health care system. The lifetime relationship the federal health care system—particularly the VA and the IHS—has with its patients should encourage federal practitioners to intervene early in the

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diagnosis and treatment of tobacco addiction and COPD. Most smokers in the United States, more than 70%, want to quit smoking. With good smoking cessation programs, 20% to 40% of participants are able to quit and remain free of the habit.[13] Federal practitioners are, therefore, obligated to provide smoking-cessation counseling and pharmacologic treatments. Federal practitioners should, furthermore, press for smoke-free environments in the VA, the DoD, and the IHS. ●

Author disclosures

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