

Fundamentals of
Clinical Practice

Second Edition



Edited by
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Warren L. Holleman
and **Scott A. Fields**

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C. Special Problems

The Tobacco Pandemic

Alan M. Blum and Eric J. Solberg

CASE 30-1

Jane L., a 28-year-old graduate student, is waiting to see her family physician for her annual well-woman examination. She is concerned about an article that she recently read in Mademoiselle. The author warned of dangers associated with the use of oral contraceptives by women who smoke. Jane L. smokes one pack a day of Marlboro Lights 100s. Accordingly, she has decided she would like to stop taking the pill and get fitted for a diaphragm. Rather than simply acquiescing to the patient's request, the physician seized the opportunity to help the patient make the connection between health improvement and cessation of smoking, and to explain the relative risk of smoking compared with oral contraceptives. The patient expressed a desire to stop smoking and asked for help in doing so.

EDUCATIONAL OBJECTIVES

1. Identify obstacles to tackling tobacco problems, from challenges in working with individuals who smoke to barriers in curbing tobacco industry marketing practices
2. Better understand common myths surrounding tobacco use and its promotion, and be able to identify the origins of those myths
3. Develop positive, office-based strategies in dealing with tobacco use, including strategies for the overall office environment and clinical strategies for assisting individuals who smoke
4. Distinguish the differences between the traditional medical/pharmacological model of smoking cessation and consumerist/behavioral approaches to smoking cessation
5. Understand the forces that shape individual and public attitudes regarding tobacco use and its promotion.

INTRODUCTION

As Case 30-1 illustrates, in only a few minutes there is much a physician can do to motivate patients to stop smoking. Such active interventions are more effective than relegating this task to ancillary personnel, a smoking cessation clinic, or a pamphlet off the shelf.

The biggest obstacle to tackling the tobacco problem is complacency—on the part of the public and health professionals alike—stemming from the belief that the war on smoking has been won (Blum, 1992). Although there is hardly a child or adult who has not heard that smoking is dangerous to health, the fact remains that the incidence of smoking has declined by less than 1% per year in the United States over the past decade. Moreover, women, teenagers, blue-collar workers, and minority groups in general are not appreciably reducing their cigarette consumption (Blum, 1993; Department of Health and Human Services, 1998).

Cigarette smoking is the chief avoidable cause of death and disease in our society. Each year smoking is responsible for 18% of all deaths in the United States (Pollin & Ravenholt, 1984). Approximately 40% of all deaths from cancer and 21% of deaths from cardiovascular disease are caused by smoking (DHHS, 1989). Tobacco use contributes to more than 400,000 deaths annually in the United States, and more than 3 million annually worldwide (Centers for Disease Control, 1994). Although cigarette smoking among adults declined from 42% to 27% in the United States during the 23 years following publication of the first Surgeon General's report on smoking and health in 1964, 26.4% of men and 22% of women continue to use tobacco regularly (Centers for Disease Control, 2000; McGinnis & Foege, 1993; Pierce *et al.*, 1989).

Ending the tobacco pandemic is not a *static* effort whereby health professionals educate the public about the adverse health effects of smoking in the hope that individuals will change their behavior, but rather a *dynamic* one whereby the tobacco industry changes its tactics to anticipate all efforts to discourage tobacco use (Blum & Solberg, 1992). As physicians and other health professionals work with their patients to end their smoking, cigarette companies continue to advertise their products, spending more than \$6.7 billion on advertising each year, touting low-tar, implicitly "safer" cigarettes, with reduced prices and coupons for increased savings (Federal Trade Commission, 2000). Physicians should point out to patients who smoke that buying a \$3 pack of cigarettes is a real "rip-off," especially considering that a pack costs less than 25 cents to manufacture. One patient, after smoking more than two packs a day for 20 years, realized he had "smoked a Porsche."

Concerns about smoking have long been raised in the scientific community. In 1928 Lombard and Doering reported a higher incidence of smoking among patients with cancer than among controls (Lombard & Doering, 1928). Ten years later, Pearl reported that persons who smoked heavily had a shorter life expectancy than those who did not smoke (Pearl, 1938). In 1939 Ochsner and DeBaakey began reporting their observations on the relationship between smoking and lung cancer (Ochsner & DeBaakey, 1939). They and other outspoken opponents of smoking, such as Dwight Harkin and William Overholt, were met with derision by the medical profession, more than two-thirds of whom smoked.

Not until the epidemiological work in the 1950s of Doll and Hill (1956) in the United Kingdom and Hammond and Horn (1958) in the United States did the medical profession begin to take the problem seriously. Since that time, information about the health risks associated with smoking has been well publicized in the medical literature. The first U.S. Surgeon General's Report on Smoking and Health in 1964 concluded that cigarette smoking was the major cause of lung cancer in men. Besides lung cancer, smoking is a major cause of cancers of the larynx, oral cavity, and esophagus. It is a contributory factor in cancers of the pancreas, bladder, kidney, stomach, and cervix. Recent studies implicate smoking in leukemia, colon cancer, Graves' disease, depression, and renal disease in persons with diabetes mellitus (Blum, 1993). A dose-response relationship exists between smoking and all of these diseases.

Cigarette smoking is a primary risk factor for coronary heart disease (CHD). Overall, those who smoke have a 70% greater CHD death rate, a two- to fourfold greater incidence of CHD, and a two- to fourfold greater risk for sudden death than nonsmokers (DHHS, 1982). The risk of stroke increases with the number of cigarettes smoked. The incidence of stroke among persons who smoke is 50% higher than among persons who do not smoke (Wolf *et al.*, 1988). Cigarette smoking is also the main cause of chronic obstructive pulmonary disease (COPD), which is the leading cause of disability in the United States.

More than 44 million Americans have stopped smoking cigarettes. Unfortunately, some 47 million Americans continue to smoke cigarettes (which represents only a slight decline in actual numbers since 1964),

despite the consequences of smoking to their health (CDC, 2000). Moreover, the cohort of smokers is younger than ever. Smoking cessation has major and immediate health benefits for men and women of all ages. The 1990 Report of the Surgeon General outlines the benefits of smoking cessation. The report concludes that smoking cessation decreases the risk of lung cancer, other cancers, heart attack, stroke, and chronic lung disease. For example, after 10 years of abstinence, the risk of lung cancer is about 30 to 50% of the risk in people who continue to smoke, and after 15 years of abstinence, the risk of CHD is similar to that of persons who have never smoked (DHHS, 1990a).

CASE 30-2

Dr. Susan Murphy was invited to speak to a health class of junior high school students. She began by asking the students to recall advertising images from the most familiar cigarette and spitting tobacco brands. The students reported that Latino- and African-American men often smoked menthol brands, such as Newport, Salem, and Kool; several members of a low-riders club used Skoal; and most of the teenage girls who smoked bought Marlboro Lights. The students began to discover the effectiveness of the advertising and marketing efforts of the tobacco companies. Several students mentioned that their parents bought Basic, Doral, or GPC because these were cheaper.

WOMEN AND MINORITIES

In 1964, at the time of the first Surgeon General's Report discussing the smoking epidemic, lung cancer was the leading cause of death due to cancer in men and the fifth leading cause of cancer mortality among women (Blum, 1993). This difference in lung cancer mortality between the genders can be explained by the fact that until the 1920s, it was socially unacceptable—and in some states illegal—for women to smoke. Men had taken up cigarette smoking in large numbers toward the end of the nineteenth century—in part because antispitting ordinances to curtail the spread of tuberculosis had led the tobacco companies to switch from the promotion of chewing tobacco and cigars to the inhalation of tobacco smoke by means of the cigarette (Blum, 1993). Smoking did not take hold among women until the American Tobacco Company began a mass media advertising campaign for its Lucky Strike brand with the enticement, "To keep a slender figure, reach for a Lucky instead of a sweet." Cigarette smoking among women rose steadily. In the 1960s the women's liberation movement led cigarette companies to introduce brands such as Virginia Slims, with the slogan, "You've come a long way, baby."

By 1985 more women than men smoked, and lung cancer had surpassed breast cancer as the leading cause of cancer deaths among women. Cigarette smoking leads to other problems for women, especially during pregnancy. There is a confirmed association between maternal smoking and low-birth-weight infants, and there is an increased incidence of premature birth, spontaneous abortion, stillbirth, and neonatal death (Centers for Disease Control and Prevention, 1988; Rakel & Blum, 1995).

African-Americans and Latino-Americans have the highest rates of lung cancer and cardiovascular disease in the United States (DHHS, 1985). The disproportionately high rates of smoking-related diseases among ethnic minorities can be attributed to the successful marketing of tobacco products to minority communities (Blum, 1989). Until their removal in 1998, billboards advertising cigarettes appeared four to five times more often in inner-city neighborhoods than in middle-class suburbs (Scenic America, 1990). Cigarette advertising in black and Hispanic magazines and newspapers continues to represent a major source of revenue for these publications. In more than 40 years of publication, the leading black-oriented magazine, *Ebony*, has carried almost no articles on smoking; not surprisingly, cigarette companies are leading advertisers (Blum, 1989).

The tobacco industry has been especially adept at exploiting racial identity in defining a profitable market among ethnic minorities. R.J. Reynolds Tobacco Company, maker of Salem, More, Camel, and

WOMEN AND SMOKING

The top row features two advertisements for Lucky Cigarettes. The left ad shows a woman with short, curly hair looking upwards, with the text "To keep a slender figure No one can deny..." above her. Below her is a circular logo that says "Reach for a LUCKY instead of a sweet" and a pack of Lucky Cigarettes with the tagline "It's toasted". The right ad shows a woman's profile with the text "AVOID that future SHADOW" above her. Below her is a circular logo that says "When Tempted Reach for a LUCKY" and a pack of Lucky Strike Cigarettes with the tagline "It's toasted".

The bottom row features two advertisements for Virginia Slims. The left ad shows a woman in a business suit and coat carrying a briefcase, with the text "VIRGINIA SLIMS" at the top. Below her is a small inset image of a group of women and the text "There used to be a lot more pressure for a woman to carry on double-breasted". The right ad shows a woman in a business suit and coat, with the text "With Super Slims Your World Size" at the top. Below her is a pack of Virginia Slims Super Slims cigarettes and the text "YOU'VE COME A LONG WAY, BABY".

At the bottom of each advertisement is a Surgeon General's warning. The left ad's warning reads: "SURGEON GENERAL'S WARNING: Quitting Smoking Now Greatly Reduces Serious Risks to Your Health." The right ad's warning reads: "SURGEON GENERAL'S WARNING: Quitting Smoking Now Greatly Reduces Serious Risks to Your Health."

At the turn of the twentieth century, cigarette smoking was socially unacceptable for women. In fact, smoking by women in public places met considerable opposition. In 1904, a policeman in New York City arrested a woman for smoking a cigarette in an automobile, with the admonition, "You can't do that on Fifth Avenue" (Sullivan, 1932). Smoking by female schoolteachers was considered grounds for dismissal (Sobel, 1978). In 1910, Alice

Longworth, President Roosevelt's daughter, was scolded for smoking in the White House and retorted she would smoke on the roof (Sullivan, 1932). (She later appeared in an advertisement for Lucky Strikes cigarettes).

In 1923, only 5% of all cigarettes were consumed by women, increasing to 12% by 1929. The increase in smoking rates among women coincides with the direct appeal to women in cigarette advertising beginning in the mid-1920s. Marlboro cigarettes were first designed as a brand only for women, and were promoted with slogans such as "Mild as May" and "Red Tips for your Pretty Lips."

The most renowned advertising campaign of the period directed at women was the association of cigarette smoking with staying slim, launched in 1928 with advertisements carrying the slogan "Reach for a Lucky Instead of a Sweet." To this day, the Lucky Strike campaign is considered one of the greatest successes in advertising history.

By the mid-1960s and the launch of Virginia Slims cigarettes, 33% of women in the United States smoked cigarettes. Because of Virginia Slims's perceived popularity (attained through intense advertising and promotion through women's professional tennis tournaments), it is often believed that Virginia Slims is the leading women's cigarette. In fact, women who smoke today buy Marlboro Lights more than any other brand.

Winston, has sponsored street fairs and fashion shows in Latino- and African-American neighborhoods. Throughout the 1980s Brown and Williamson Tobacco Company, manufacturer of Kool, presented annual Kool Achiever awards to people who improved the "quality of life in inner-city communities." For decades, major African-American and Latino civic organizations, such as the NAACP, the Urban League, the United Negro College Fund, and La Raza, have received funding from tobacco companies.

The result of such successful marketing targeted to ethnic minorities is a higher rate of smoking among African-Americans and an increase in smoking among Hispanic women. Data from the 1998 Surgeon General's Report reveal that 26.5% of African-Americans smoke compared with 25% of the white, non-Hispanic population (CDC, 2000; DHHS, 1998).

CASE 30-3

Billy J. is an 8-year-old who presents with a persistent cough. This is his third visit over the past 3 months, during which time he has missed several days of school. The principal has requested a physician's note to explain Billy's absences. Billy's parents are frustrated and believe that Billy is faking or exaggerating his symptoms to avoid school. Neither Billy nor his parents smoke, but the woman who takes care of him after school smokes in her house.

INVOLUNTARY OR PASSIVE SMOKING

Billy's parents should be made aware that two-thirds of the smoke from a burning cigarette never reaches the lungs of the person who smokes, but instead goes directly into the air (DHHS, 1986). The 1986 Report of the Surgeon General, dedicated to a discussion of involuntary or passive smoking, defined environmental tobacco smoke (ETS)—also called secondhand smoke—as the combination of sidestream smoke that is emitted into the air from a burning cigarette between puffs and the fraction of mainstream smoke that is exhaled by one who smokes.

The effects of tobacco smoke on nonsmokers can be significant. An estimated 3000 nonsmokers die each year from secondhand smoke (National Institutes of Health, 1993). Fifteen percent of the U.S. public is

allergic to cigarette smoke. Numerous studies have explored the health risks of the nonsmoker who is exposed to ETS. The toxic and carcinogenic effects of ETS are similar to those of tobacco smoke inhaled by active smokers. At least 14 studies have demonstrated a risk of lung cancer in nonsmoking wives exposed to the secondhand smoke of their husbands (Rakel & Blum, 1995). Some studies have found that passive smoking increases the risk of leukemia, lymphoma, and cancer of the breast and uterine cervix.

The risks of passive smoking extend beyond cancer. It is estimated that tobacco smoke in the home and workplace could be responsible for the deaths of 46,000 nonsmokers annually in the United States (NIH, 1993). Most of these, 32,000, are the result of heart disease, making passive smoking the third leading preventable cause of death after smoking and the consumption of alcohol.

Parents who smoke are more likely to have children who will smoke. The risk of a child taking up smoking increases with each additional adult family member who smokes (Rakel & Blum, 1995). Over 50% of children under 5 years of age live in homes with at least one adult who smokes. Children of smoking parents are more likely to suffer from otitis media, bronchitis, and pneumonia. Numerous studies have shown that the increased incidence of cough, bronchitis, and pneumonia in children of smoking parents is proportional to the number of cigarettes smoked by the parents, particularly the mother (Rantakallio, 1978). Asthma is also more prevalent, and passive smoking has been linked to some instances of sudden infant death syndrome (Rantakallio, 1978).

CASE 30-4

Tim S. is a fourth-year medical student completing a dermatology elective. A patient he has seen for dry skin returned for a follow-up visit to get a renewal on a prescription for a moisturizing lotion. While she is waiting to speak with her physician, Tim recognizes her and asks if she has stopped smoking yet. She replies by saying she really did try, but that the stress at work and home have been unbearable, and she does not want to gain back the weight that she just lost. "I'm not ready to quit," she explains. However, she adds that she switched to a lower-tar brand and now actually smokes more cigarettes per day than ever before. Tim tells her that her smoking may contribute to her skin problem, and that if she doesn't stop she may not see much improvement. Tim tells her that her stress is just an excuse for not quitting, and warns her of the serious danger smoking is to her health.

SMOKING CESSATION

Rather than scold his patient for not listening to him previously about the adverse health effects of smoking and the importance of stopping in Case 30-4, Tim should have used this opportunity to serve as a consumer advocate as much as a health nanny. Tim could have helped this patient not by remonstrating, but rather by suggesting that the stress she feels impelling her to light up a cigarette may in large measure reflect her dependence on nicotine and by correcting the myth that smoking low-tar cigarettes is safer.

Low Tar Means Low Poison

In the 1950s, confronted with declining cigarette sales after the publication of studies linking smoking to lung cancer, tobacco companies began producing filter-tipped brands and claimed that these filters removed certain components of smoke (which manufacturers have never acknowledged to be harmful) (Miller, 1985). Brown and Williamson Tobacco Company purchased advertising space in the Medicine section of Time to claim that Viceroy cigarettes offered "double-barrel health protection," and advertisements for Liggett and Myers's filter L & Ms claimed they were "just what the doctor ordered." Until the 1960s (and until the 1980s in Kentucky) tobacco companies promoted cigarette at meetings of the American Medical Association and state medical associations by means of scientific exhibits that sought to demonstrate the alleged benefits of

one brand over another (Blum, 1992). Consumer demand soared. Currently, 97% of those who smoke buy filtered brands.

In the late 1960s, to allay public anxiety about cancer, tobacco companies began marketing brands with purportedly lower levels of "tar" and nicotine. Throughout the 1970s the American Cancer Society, the National Cancer Institute, and most major health organizations promoted the concept of a safer cigarette in the belief that most people who smoke cannot stop. Persons who switch to allegedly low-tar cigarettes have been found to employ compensatory smoking, whereby they inhale more frequently and more deeply to maintain a satisfying level of nicotine (Miller, 1985; Rickert, 1983). More simply, for the purpose of educating the patient who smokes, "low tar" can be translated as "low poison." Tar is a composite of more than 4000 separate solid poisons, including at least 43 known carcinogens. Cigarettes with reduced yields of tar, nicotine, and carbon monoxide are not safer. A recommendation to switch to such brands is misguided.

Debunking Common Myths

An important myth surrounding smoking is that it relieves stress. This idea can be debunked by pointing out that the stress that is relieved is that which resulted from being dependent on nicotine—this is the essence of addiction. At the same time, deep breathing has a relaxing effect. The physician can suggest that the patient try to postpone for 5 minutes every time she intends to light up, then breathe slowly and deeply for 5 minutes, then reconsider whether the cigarette is important.

Another myth reinforced in advertisements for Virginia Slims and other cigarettes aimed at women and girls is that smoking keeps weight off. The woman who stops smoking need not gain weight if she relearns the joy of walking and other activities as much as she relearns the taste of food. By no means will all persons who stop smoking gain weight. Even among those who do, the average weight gain is less than 5 pounds (DHHS, 1990a).

Perhaps the biggest myth that has been encouraged in the medical literature is that the patient must be "ready to quit." Although common sense dictates that those who express a greater interest in smoking cessation will have a greater success rate, those patients who do not express an interest in smoking cessation symbolize the overall challenge to be faced in ending the pandemic. Setting a quit date, the essential element of the smoking cessation literature, may rationalize the continuation of an adverse health practice and may strengthen denial. It is helpful to remind patients that they can stop now.

Consumer Advocacy Role

Traditional office-based approaches begin by asking, "Do you smoke?" "How much do you smoke?" and "When did you start smoking?" Although this may provide the physician with relevant data for charting purposes, this approach is too often a signal for the patient to become defensive and resistant to further discussion, especially if the patient had no intention to stop smoking. There are alternative ways of obtaining information and at the same time piquing the patient's interest in the subject. By using and identifying with the vocabulary used by the consumer of cigarettes, the physician can adopt and be perceived in the role of consumer advocate as opposed to medical finger-wagger. The most important and nonthreatening questions to ask are, "What brand do you buy?" and "How much do you spend on cigarettes?" The patient is likely to be surprised and intrigued by these questions, which can be asked at any time in the course of the interview, because they appear to be nonjudgmental. They suggest that the physician is not a know-it-all and a polemicist. A question about the cost of cigarettes shows concern for the patient's financial well-being.

Promotions for various pharmacologic agents, mail-order gadgets, and clinics in smoking cessation reinforce the notion that cigarette smoking is primarily a medical problem with a simple, easy-to-prescribe, nonindividualized solution. When a patient requests a "drug that will help me stop smoking," the physician must confront the dilemma of not wanting to dash the patient's expectation while emphasizing that a drug or device is, at best, an adjunct and not a means of smoking cessation.

Ironically, as pharmacies in the United States in recent years have become sites for screening of blood pressure, reading of Hemoccult tests, and monitoring of diabetes, cigarettes have become a staple of chain drug stores. Is there any doubt that some patients who smoke rationalize their adverse health behavior by pointing to the sale of cigarettes at the very place where they are directed by physicians to obtain medications (Richards & Blum, 1985)? Although independently owned pharmacies by and large began discontinuing the sale of tobacco products in the late 1970s, more and more of these pharmacies have been acquired by the major chain drug stores, including Eckerd, Walgreens, Rite-Aid, and CVS, all of which prominently display cigarettes at the checkout counter. (Moreover, major supermarkets and discount stores such as Walmart also maintain both pharmacies and tobacco products sections). Thus, incredible as it may seem, the number of pharmacies in the United States that sell cigarettes has actually risen as a result of the concentration of ownership by large chains. In contrast, then, to their staunch support of health fairs and programs to detect and treat hypertension, diabetes, and colon cancer, no retail pharmacy chain has either stopped selling cigarettes or supported paid mass media campaigns to reduce demand for tobacco products. The problem is compounded by the fact that health insurance companies continue to award major employee prescription drug plan contracts to the large chain pharmacies. As a consequence, independent pharmacies cannot compete on price, and many small communities have seen the last local corner pharmacies absorbed by conglomerates.

Personalize and Individualize

In addition to debunking common myths surrounding smoking, the physician can learn to personalize approaches to smoking cessation by carefully screening the pamphlets and other audiovisual aids available in the office. It is essential to scrutinize all such material, as one would with a new drug or medical device. Personally handing a brochure to a patient while pointing out and underlining certain passages or illustrations will provide an important reinforcing message. Individualizing the message to the patient is the cornerstone of success in patient education. The same cigarette counseling method cannot be used for a high school girl, a construction worker, and an executive already showing signs of heart disease. In the case of a high school girl, the physician should not focus on such abstract concepts as emphysema and lung cancer, but rather emphasize the cosmetic unattractiveness of yellow teeth, bad breath, the loss of athletic ability, and the financial drain that results from buying cigarettes. As for the construction worker, the physician might suggest the likelihood of fewer lost paydays, greater physical strength, and even a lengthier sex life were he to stop smoking cigarettes.

In any event, such dialogue must be practiced over and over again like any medical procedure, and individualized to the patient. The counseling should be designed to call attention not only to the inevitable risks of smoking cigarettes but also to the chemically adulterated tobacco product itself, its inflated price, and the ubiquitous and ludicrous way in which the person's brand is promoted. In effect, the physician can shift the focus away from a resistant or guilt-ridden smoker and onto the product.

CASE 30-5

Dan Glatt, a fourth-year medical student and delegate to the American Medical Association's (AMA) Student Section, worked collaboratively with peers and colleagues to submit a resolution in 1992 for the AMA to adopt a policy stating that the AMA would no longer accept financial support from tobacco companies. A separate resolution submitted by another section of the AMA called for the AMA to "discourage all medical schools and their parent universities from accepting research funding from the tobacco industry."

TOBACCO USE AND SOCIETY

In 1964, the AMA refused to join other health organizations in immediately endorsing the Surgeon's General's Report on Smoking and Health. Between 1964 and 1978 the AMA accepted upwards of \$18 million

from the tobacco industry, purportedly to conduct additional research to verify the findings of the Surgeon General's Report.

The ethical issues described in Case 30-5 arose primarily from a \$250,000 grant that Fleischmann's Margarine gave the AMA for an anticholesterol campaign. Fleischmann's, at that time, was owned by tobacco giant R.J. Reynolds. Similarly, the AMA received advertising revenue from tobacco company-owned products, such as Philip Morris-owned Kraft and R.J. Reynolds-owned Nabisco, for their cable television ventures. The AMA's Board of Trustees defended their acceptance of money from tobacco company "subsidiaries" by saying that they funded important public health programs.

The proposals by Dan Glatt and his colleagues were referred to the Board of Trustees, as the AMA House of Delegates directed the Board to report back in 6 months with a "definition" of a tobacco company (Wolinsky & Brune, 1995). The resulting definition would thus apply to any AMA policy on nonacceptance of funds from tobacco companies and the AMA's encouragement of medical schools to end their acceptance of research support from the tobacco industry.

These proposals did not represent the first time that the AMA's ties with the tobacco industry were called into question. Nor was it the first time that medical students and residents were the originators of the debate. In 1979 a few resident physicians learned that the AMA's Members Retirement Fund owned \$1.4 million in tobacco securities (Blum, 1983b). In 1980, a handful of residents persuaded the AMA Resident Physicians Section to present a resolution to the House of Delegates declaring "the AMA fiduciary responsibility to the public is greater than its fiduciary responsibility to its investment portfolio," and asked for the divestment of the tobacco stock (Wolinsky & Brune, 1995). The AMA Board's finance committee chairman argued that the purpose of the pension fund was to make the biggest buck, not to make social statements. Other AMA officials attempted to minimize the issue by noting that tobacco companies were highly diversified and were involved in nontobacco industries.

The residents' resolution was defeated by the AMA, but after the resulting bad publicity the AMA received in national media for defeating the proposal, the portfolio managers sold the tobacco stock. In 1985, the AMA officially informed its investment brokers that tobacco securities could not be purchased without prior approval by the AMA Board or its finance committee (Wolinsky & Brune, 1995).

Dan Glatt in Case 30-5 and his colleagues in the Medical Student and Resident Physicians Sections of the AMA knew that their resolutions to end financial support of the AMA and medical schools by tobacco companies would not be well received by executives at the AMA, nor by the deans of medical schools and their parent universities. In June 1993, the AMA Board unveiled its definition of the tobacco industry. The AMA defined the tobacco industry as "companies or corporate divisions that directly produce or market tobacco products along with their research and lobbying groups including the Council for Tobacco Research and the Tobacco Institute" (American Medical Association, 1993). The definition continued that "a company or corporate division that does not produce or market tobacco products, but that has a tobacco producing company as or among its owners should not be considered a prohibited part of the tobacco industry." In other words, under the definition the AMA could not deal directly with tobacco companies, but could continue to trade with the companies' subsidiaries so long as they were not involved in the promotion of tobacco products, leaving the ethical question open for further debate.

By the late 1990s, without ever having either acknowledged or apologized for its own role in aiding and abetting the tobacco industry during the crucial years following publication of the Surgeon General's Report, the AMA had positioned itself as a visible player in the public relations campaign against smoking. Its flagship journal published a considerable number of antitobacco articles, and in 2000 the AMA served as a co-host of the 11th World Conference on Tobacco OR Health. Yet in spite of increased awareness on the part of both the medical community and the general public of the devastating health and economic toll taken by the use of tobacco, concerted efforts to curtail demand for these products have been undermined by both direct and covert financial ties between the tobacco industry and respected sectors of society.

In 2000, in the face of a jury's decision that tobacco companies must pay \$144.8 billion to Floridians

WHEN DOCTORS SMOKED



Doctor,
be your own
judge...
try this
simple test

When you smoke
Philip Morris cigarettes,
you'll find the difference
in taste. You'll find
the taste of a cigarette
that's been smoked
by a doctor.

Take a PHILIP MORRIS and any other cigarette.

1. Light an either one. Take a puff, get a good mouthful of smoke, and swallow it. Let the smoke come down to your throat.
2. Now, do exactly the same thing with the other cigarette.

Notice that PHILIP MORRIS is definitely less irritating, definitely milder.

PHILIP MORRIS

Philip Morris Inc., N.Y.C. 100, N.Y. 100, N.Y.

No irritative power is claimed for
PHILIP MORRIS . . . but

AN OUNCE OF PREVENTION

is worth a pound of cure!

PHILIP MORRIS are scientifically proved
far less irritating to the nose and throat

When smokers changed to
Philip Morris, substantially
every case of irritation of the
nose or throat—due to smoking
—either cleared up completely,
or definitely improved!

—from the findings of a group of distinguished doctors

CALL FOR PHILIP MORRIS

FAR FINER FLAVOR—PLUS FAR MORE PROTECTION

Even before the first widely publicized scientific reports were published linking smoking to a host of diseases, tobacco companies were using health claims in cigarette advertisements. Lucky Strikes, the top-selling and most advertised brand in the 1930s, used health-oriented slogans like "No throat irritation, No cough," while Old Gold's claimed "Not a Cough in a Carload." A number of such health claims originated in cigarette advertisements in medical journals. Between 1933 and 1954, cigarette advertisements appeared regularly in peer-reviewed medical journals such as JAMA, state medical society journals, and even *The Laryngoscope* and *the Women's Medical Journal*. A number of tobacco companies used physicians in their advertisements, such as Philip Morris's "Doctor, be your own judge," which encouraged physicians to try Philip Morris cigarettes and advise their patients to switch to the "less irritating, definitely milder" Philip Morris brand. "More Doctors smoke Camels" was a popular theme for R.J. Reynolds in the 1940s that made its way to the popular press and prime-time radio and television. Beginning in 1942, R.J. Reynolds invited physicians to visit the Camel cigarette exhibit at the convention of the



In recent months we have received a number of reports from physicians who recommend Camels to their patients. Perhaps you, too, advise Camels in cases where nicotine reduction is desirable. If so, we will be pleased to add your experiences to our files. May we hear from you from time to time?

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[illegible]

● **ASPIRIN IN THE PREVENTION OF MYOCARDIAL INFARCTION**—“The Physicians’ Health Study and The Nurses’ Health Study II have begun, but the results are not yet available.”

Camel—The Cigarette of Costlier Tobaccos

American Medical Association. More than 40 years after cigarette advertisements disappeared from peer-reviewed medical journals, it seems inconceivable that they ever could have been accepted in the first place. Yet many of the throw-away medical magazines continued to accept cigarette advertising throughout the 1960s and 1970s. At least one magazine, Physician East, published in Boston, accepted cigarette advertising as late as 1983 (Blum, 1983a).

Young Man
in
White

[illegible]

According to a recent Nationwide survey

**MORE DOCTORS SMOKE CAMELS
THAN ANY OTHER CIGARETTE**



● The makers of Camel take an understandable pride in the number of a nationwide survey showing 113,502 drivers for their leading independent research organization.

When quoted about the cigarette they themselves smoked, the brand named most by the drivers was... Camel.

If you, too, are looking for pleasure, The rich, full flavor and good mildness of Camels are just as good as looking for a new one.

CAMELS *Castles
Tobacco*

made ill by smoking (the largest punitive damages award in legal history), investment firms attempted to bolster public confidence in the tobacco industry. After predicting solid returns for investors in tobacco, Credit Suisse First Boston underwrote \$3 billion in bonds for Philip Morris. *The New York Times*, which proudly proclaimed in 1999 that it would decline cigarette advertisements, joined the television networks and most major newspaper and magazine publishers in continuing to accept advertisements from cigarette manufacturers touting their charitable endeavors. Philip Morris, renamed in the advertisements “the Philip Morris Family of Companies,” spent four times the amount of its charitable contributions on promoting its good deeds.

Most glaringly, most pension funds and university endowments continue to invest in tobacco stocks. In 2000, while administering the \$22 million Tobacco-Related Diseases Research Program funded by taxes, the Board of Regents of the University of California also oversaw an investment of \$55 million in tobacco companies from the university's endowment and pension funds. Ironically, the University has been sued twice by the tobacco industry aimed at derailing academic research into industry activities.

Although in 1999 Yale University joined a handful of other educational institutions in banning the sale of tobacco products on campus, Yale's president stated he did not feel that the University's ongoing investments in tobacco stocks are unethical. Similarly, in the mid-1990s Rice University, among the leaders in academia in tobacco investments, rebuffed a call by 80 alumni to divest its \$33 million in tobacco holdings, reasoning that the high stock dividends helped hold down tuition. In 1998 and 1999, Rice earned several hundred thousand dollars for hosting the George Strait Country Music Festival on its campus, two of the most prominent sponsors of which were GPC cigarettes, manufactured by Brown & Williamson Tobacco Company, and Skoal, made by the United States Smokeless Tobacco Company (UST). Free samples of cigarettes and spitting tobacco were distributed at the events, and UST passed out fliers urging voters to turn down all

tobacco tax increases. When a lecturer in a premedical course on cancer posed questions about the University's role in aiding the tobacco companies, the president of Rice refused to respond.

One of the most open relationships between an educational institution and the tobacco industry (apart from agricultural colleges working to improve the crop) can be found at Syracuse University, which participates in Philip Morris's Student Ambassador Program. Undergraduates hired by the company for summer internships are paid to promote the image of the company to faculty, administrators, and fellow students. While highlighting the company's charitable endeavors and food product divisions, Philip Morris recruits students at campus job fairs for positions as "Territory Sales Managers," which in reality involve promoting Marlboro at retail outlets. Also at Syracuse, the Louis Bantle Institute, named for a past chairman of UST, has invited leaders of the tobacco industry to speak on campus. It was endowed by an alumnus and trustee who is credited with having popularized smokeless tobacco use throughout the United States by means of clever marketing and having propelled sales into the billions of dollars (personal communication, Leon Blum, 2001).

CASE 30-6

Susan Evans, a first-year resident in family medicine, worked as a volunteer of the community-based health charity as part of the requirements for a preventive medicine and health promotion curriculum of her residency program. The organization asked her to help them develop a curriculum for tobacco prevention to be implemented in area schools.

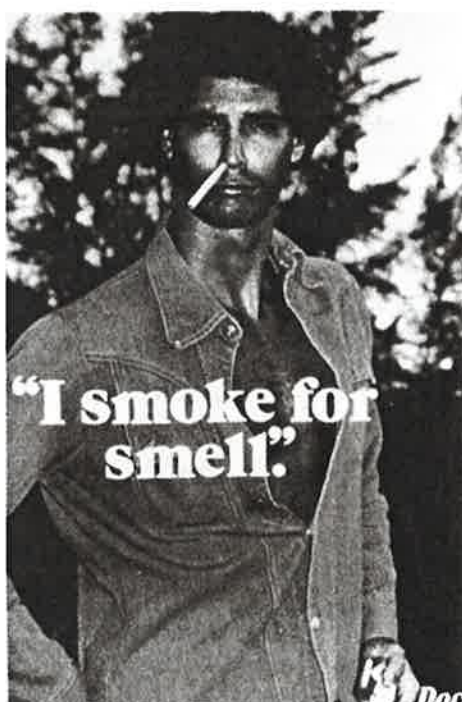
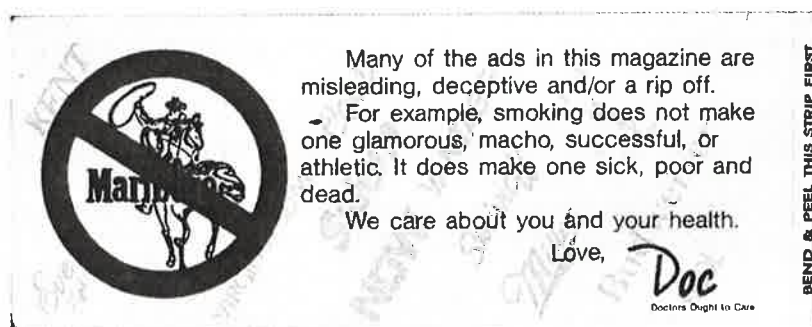
Susan began her work by researching resources and other agencies that work on the tobacco issue. In addition to the information she received from traditional voluntary health agencies, primarily restricted to pamphlets about the dangers of smoking, one organization called DOC (Doctors Ought to Care) provided her with materials developed for health professionals to present in the school classroom. To Susan's credit, she did her homework. Rather than try to reinvent the wheel, Susan discovered that much of the initial work and research had already been done, and she simply needed to focus on implementation.

MEDICAL ACTIVISM: BEYOND THE EXAMINING ROOM

DOC, the example provided in Case 30-6, was founded in 1977 to educate the public, especially young people, about the major causes of poor health and high medical costs. One of DOC's primary objectives has been to tap the highest possible level of commitment from every health professional to combat the promotion of lethal lifestyles in the mass media. Unfortunately, public health issues and health promotion do not receive the attention they should in medical schools and residency programs. Indeed, within the medical profession, incentives for health promotion have never been strong. Put in these challenging terms, there is understandable discomfort, skepticism, and even resistance by many physicians to health promotion efforts. Many physicians question why the responsibility, or onus, of health promotion should fall to the physician. To the busy practitioner, health promotion does not appear to be time-effective or cost-effective. For these reasons, a more concerted effort is needed to involve medical students, residents, and physicians in health promotion efforts.

To confront the tobacco pandemic, numerous strategies can be implemented in the clinic, classroom, and community (Blum, 1992). Some of the clinical approaches have been described earlier in this chapter. But the messages imparted in the clinic must be reinforced outside the office. To this end, school-based programs must be made more engaging, placing an equal emphasis on what could be called the "three Ps": peer pressure, parental modeling, and propaganda. Too few educational programs in or out of the classroom, especially in primary schools, go beyond scare tactics and cognitive objectives about the dangers of smoking.

MEDICAL ACTIVISM



In any clinical setting, the entire office staff must work to create an environment that encourages nonsmoking behavior. Even before a physician's individual encounter with a patient, steps can be taken to provide positive health messages. As part of the professional office, the reception area automatically grants credibility and implies endorsement to whatever editorial or commercial material it may contain. Indeed, Time, Newsweek, Sports Illustrated, Better Homes and Garden, Ladies Home Journal, and People—the most frequently purchased magazines for doctors' offices (National Cancer Institute, 1994)—have many advertisements encouraging and glamorizing tobacco use. Healthcare professionals can send a message to patients and publishers alike by canceling subscriptions to these publications and subscribing to publications that do not promote tobacco (NCI, 1994). An alternative technique is to call attention to the harmful and untruthful nature of these advertisements by pasting stickers on them such as the one developed by DOC (Doctors Ought to Care) in the illustration on the left. Other areas of the office, such as restrooms and even the ceilings of examination rooms, can be provided with eye-catching posters that poke fun at tobacco use and its promotion.

By analyzing and satirizing the promotional techniques of tobacco companies and their media allies, students can delight in turning the tables on the firms that create cigarette advertisements. In studying the long arm of the tobacco industry around the world and making the connection between tobacco advertising and the deaths of family members and friends from tobacco-related diseases, students may learn to redirect their anger from teachers, parents, and health professionals to the authority figures in society who attempt to promote unhealthy products to children.

Physicians and other healthcare professionals can begin their own secondary education in this effort by learning more about the tobacco industry, its products, and the way tobacco is promoted in society. The three essential tools for such research are a map, a calendar, and a camera. With these tools, one can monitor the promotional strategies of the tobacco industry in one's own community and utilize the results as part of a larger school-based or community-based educational effort.

Legislation and policy initiatives, such as a ban on tobacco advertising and promotion, would also be helpful but lack sufficient support from Congress. On the other hand, enforcement by the U.S. attorney general of existing laws that regulate tobacco advertising could be a major step forward. For example, the Public Health Cigarette Smoking Act of 1969, which prohibits the promotion of cigarette brands on television, calls for a \$10,000 fine for each violation of the law. If this law could be applied to national telecasts of tobacco-sponsored sporting events, levying fines of up to tens of millions of dollars per event—based on the hundreds of tobacco brand names shown on television during an auto race—neither media corporations nor tobacco companies could afford to continue televising tobacco-sponsored sporting events (Blum, 1991).

Until such action is taken by federal agencies, it is important to counteract such promotions at the community level. By lampooning brand names as part of paid counteradvertising and sponsoring antismoking events, DOC has been instrumental in pointing out the vulnerability of the tobacco industry. From 1978 throughout the 1990s, DOC used its version of the Virginia Slims Tennis Tournament—the Emphysema Slims, with the slogan “You’ve coughed up long enough, baby”—to counter tobacco sponsorship of sports.

The passage of smoke-free indoor legislation has been the single major advance in the United States in terms of reducing cigarette consumption, thanks to the efforts of nonsmokers’ rights groups. In simple terms, when adults learn of policies prohibiting smoking in public places and at work, they don’t light up. Among teenagers, preventive measures should focus on demand reduction, encouraging young people not to *buy* these products and to save their money.

There is great need for a no-holds-barred revocabularization, i.e., a new set of terms, images, and other symbols with which to communicate to the public about tobacco products and manufacturers (Blum, 1980). A crucial phase in U.S. public health will be reached when the six major tobacco companies in the United States are recognized as cancer’s leading warning signs: Philip Morris (makers of Marlboro and Virginia Slims), RJR/Nabisco (R.J. Reynolds Tobacco Company: Winston, Salem, and Camel), Loews (Newport and Kent), Brown and Williamson (Kool and Carlton), Liggett (generics), and UST (United States Smokeless Tobacco: Skoal and Copenhagen spitting tobaccos). Similarly, the leading preventable cause of death and disease in our society is not lung cancer, heart disease, or emphysema, but rather Marlboro, which is the leading brand among adults and adolescents.

To the physician, hard-hitting satirical counteradvertising that shifts the public focus away from the substance (tobacco, nicotine), the user (smoker), and the effects of the substance (lung cancer) to the manufactured product, the way in which it is promoted, and the promoters may seem overly political and at risk of invoking the wrath of the tobacco industry and its allies. This effect is precisely the intention. Cigarette sales have not been seriously damaged by warnings of the dangers of smoking, because danger has become part of the formula for selling cigarettes, especially to the fearless adolescent. Tobacco companies have blithely responded to thousands of research reports describing the dangers of smoking by funding hundreds more to seek further proof.

CONCLUSION

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CASES FOR
DISCUSSION

A concerted effort that includes physicians, researchers, nurses, dentists, pharmacists, and other health professionals is essential for ending the tobacco pandemic. By better understanding the opposition to this public health tragedy, with the knowledge that complacency plays a major role as a barrier to a well-coordinated effort, health professionals will gain the skills needed to become more effective in their efforts.

By studying and counteracting the tobacco industry like a parasitic disease, health professionals can begin to immunize children and change societal attitudes about smoking through humorous, positive health strategies implemented in the clinic, classroom, and community.

CASES FOR DISCUSSION

CASE 1

A medical student, on completion of an oncology elective, learns that one of the trustees on the board of the major New York City cancer center also serves on the board of Philip Morris, which is also headquartered in New York. The medical student, who has just seen firsthand the toll that tobacco use takes on patients and their families, feels compelled to present this issue to the board of trustees by encouraging a colleague to introduce the problem through a faculty committee.

1. Is it a conflict of interest for a trustee of the cancer center to also serve on the board of a tobacco company?
2. Is the medical student acting appropriately by calling attention to this issue, or should this be left to those who set policy for the cancer center?
3. Should the medical student alert others inside and outside the cancer center to this issue (i.e., the local news media)?

CASE 2

A family physician is approached by one of his patients to speak on her behalf to her employer who permits smoking throughout her worksite. The patient is allergic to tobacco smoke and, when exposed to it for long periods, experiences headaches, sneezing, and itchy, watery eyes.

1. Does the physician's obligation for his patient's health and well-being extend to such interventions at the worksite?
2. Should the physician risk the alienation of his patient by her employer?
3. What information can the physician share with the employer without breaching the trust and confidentiality of his patient?
4. How could/should the physician approach his patient's employer?

CASE 3

An otolaryngologist specializing in voice problems is invited to serve as the physician for the Houston Grand Opera. As one who enjoys the performing arts, he feels this is a good opportunity to participate in civic activities and help promote his clinic. The next morning, he reads in a newspaper report that the opera has just received a large grant from the nation's largest tobacco company, Philip Morris, which gives millions each year to support arts groups.

1. Should the physician question the support of the opera by the tobacco company?
2. Can the physician accept this position and then utilize the position to draw attention to the tobacco company's contribution?
3. Should the physician turn down the position?
4. Should the American Medical Association urge its members not to serve on the boards of opera companies, museums, and other institutions that accept money from tobacco manufacturers?

CASE 4

A physician and faculty member at a leading medical school has accepted the position of editor of a peer-reviewed medical journal. In considering manuscripts for an upcoming issue devoted to lung disorders, he is informed by a reviewer that one manuscript was submitted by researchers who formerly received funding from the tobacco industry-supported Council for Tobacco Research.

1. Is it appropriate for the editor to question the researchers about their former ties to tobacco money?
2. Should the editor reject the manuscript solely based on the source of funding provided for the study?
3. Should a pharmaceutical company that manufactures a nicotine replacement product be permitted to underwrite the cost of a special issue of the journal on smoking cessation?
4. Should researchers who have accepted funding from the tobacco industry be eligible to receive research grants from the American Legacy Foundation, which was established in 1998 with funds from the national tobacco settlement?

RECOMMENDED READINGS

Blum A (ed): *The Cigarette Underworld*. Secaucus, NJ, Lyle Stuart, 1985.

This book was published as a second printing of the December 1983 issue of the *New York State Journal of Medicine* (Vol. 83, No. 13), the first medical journal ever to devote an entire issue to a consideration of the world tobacco pandemic. Rather than a discussion of the adverse health effects associated with smoking, this book focuses on the social and political history of the leading cause of death in the twentieth century, namely, the tobacco industry.

Smith S, Smith J (eds): *Medical Activism: DOC's Approach to Countering the Tobacco Pandemic*. Houston, Tex, DOC (Doctors Ought to Care), 1992.

Outlined in this guide is a blueprint for health professionals to become more active in counteracting tobacco use and promotion. Strategies designed for the clinic, classroom, and community are highlighted, and successful examples are shared.

Wolinsky H, Brune T: *The Serpent on the Staff: The Unhealthy Politics of the American Medical Association*. New York, Tarcher/Purman, 1995.

This book provides an inside look at some of the policies developed within the American Medical Association, whose political intentions often conflict with the organization's stated public health mission.

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