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THE CENTER FOR
THE STUDY OF
TOBACCO AND SOCIETY

Role of the Health Professional in Ending the Tobacco Pandemic: Clinic, Classroom, and Community

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ABSTRACT—Physicians and other health professionals have become complacent about the tobacco pandemic, because there is a mistaken belief that the war on smoking has been won. In reality, the survival from lung cancer is little better than it was 30 years ago, and cigarettes have become the most advertised and promoted product in society. The prevalence of overall smoking in the United States has declined by only 0.5%/y during the past decade. Among certain US minority populations, the decline has been far less or nonexistent. Traditional efforts to control the tobacco pandemic have been reactive and static, whereby government agencies, schools, and health professionals provide the public with generic information about the adverse health effects of smoking. As a result of these efforts, it is assumed that individuals will act to change their behavior. In contrast, the tobacco industry is proactive and dynamic, changing its brand-name strategies through advertising and promotion. To more effectively combat tobacco use, health officials need to move beyond patient education and adopt a more active model that includes clinic-based, school-based, and community-based tobacco-control strategies. Use of humorous, satirical images as part of paid counteradvertising campaigns and proactive health education curricula should be part of a concerted effort to end the tobacco pandemic and limit the promotional influence of tobacco companies. [J Natl Cancer Inst Monogr 12:37-43, 1992]

For health professionals, especially those who work in governmental, academic, or voluntary health agency settings, this discussion may be hazardous to their preconceptions about the smoking pandemic and how to end it. 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. Although there is hardly a child or adult who has not heard that smoking is dangerous to health, the fact remains that the prevalence of smoking has declined by only 0.5%/y in the United States during the past decade (1). Moreover, women, blue-collar workers, and minority groups in general are not appreciably reducing their cigarette consumption (2).

The objective of this article is to challenge health-care

professionals to reexamine their approaches, their attitudes, and even their vocabulary to begin examining the tobacco problem as much in terms of promoting a consumerist message of not buying cigarettes as in terms of promulgating a nonsmoking health behavior. This view may lead to a better understanding of why tobacco advertising has been so much more successful than health education and why, in effect, the tobacco companies could be considered leading health educators.

PROGRESS?

Have we really come a long way? Survival from lung cancer is little better than it was 30 years ago, and cigarettes have become the most advertised and promoted product in society. To accelerate the end of the tobacco pandemic, health professionals must consider that the major preventable cause of death is not lung cancer, heart disease, or smoking; rather, it is Marlboro, which is now the most advertised brand-name consumer product in the world.

Due to the efforts of grass-roots organizations, voluntary health agencies, and progressive governments (eg, Canada, Australia, Norway, and New Zealand), tobacco use is becoming less socially acceptable. Over the past 20 years, all of the major cigarette manufacturers have dropped the word *tobacco* from their names, and smoking has lost its allure for the better educated. Among US doctors, only 1 of 10 still smokes, compared with 2 of 3 in 1950 when the first large studies confirming the link between cigarettes and lung cancer were published (3). At the same time, cigarette advertisers, whose livelihoods depend on maintaining the tobacco dependence of hundreds of millions of people worldwide (including several million teenagers each year who start smoking), remain unrestrained. It is an illusion to believe that a major mass-media effort designed to engage the public in a true understanding of the economic and physical toll taken by tobacco use exists in this country. To any adolescent who reads *Sports Illustrated*, *Rolling Stone*, *Spin*, *Playboy*, *National Lampoon*, or *Mademoiselle* (or who picks up *Time* or *Newsweek* in the school library), the presence of cigarette advertising clearly suggests that smoking is associated with good looks, sexiness, and athletic ability. These appeals to freedom, wealth, and glamour cannot have failed to undermine public health efforts.

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² The assistance of Eric J. Solberg, executive director of Doctors Ought to Care, is gratefully acknowledged.

Through ubiquitous social reinforcement of smoking as an attribute of success, the term *antismoking* now has a negative connotation among the poor and uneducated. Notwithstanding tobacco's relationship to between 30% and 40% of all cancer deaths, the mass media (covetous of tobacco advertising revenue) continues to refer to preventive-medicine advocates as "antismoking zealots." The same news corporations would hardly refer to cancer researchers as "anticancer zealots". All who work in cancer treatment, prevention, and research must remind the public at every opportunity that laboratory researchers, clinicians, and preventionists alike are not anti-smoking, but rather anti-cancer, anti-heart disease, and anti-high medical costs.

Unfortunately, too many health professionals still believe that most adverse health behavior can be attributed to peer pressure or poor parental modeling, despite the fact that most peer pressure can be molded through advertising propaganda. In the United States, one of the most ubiquitous current cigarette advertising campaigns features a camel cartoon character. Coincidentally, this brand is catching up to Marlboro as the most popular cigarette among adolescents. Is this peer pressure? Lest we think that an advertising ban will remove these influences, consider the use of movies such as *Superman*, seen by tens of millions of teenagers worldwide, which contains dozens of images of the Marlboro cigarette logo in several scenes (4), or *Days of Thunder*, with its many shots of Winston cigarette logos on racing cars.

More than \$3 billion is now spent each year in the United States alone to promote cigarette smoking (5). Despite the vaunted claims of tobacco executives that cigarette advertising is aimed solely at enticing the confirmed adult user to switch brands—and never at adolescents—it is irrefutable that every advertisement for cigarettes represents an encouragement to smoke and a reinforcement of the social acceptability of smoking.

Tobacco companies, individually and collectively as the Council for Tobacco Research, continue to provide funding to medical schools for smoking-related research, as if to imply that more research is really necessary to settle what the industry calls the smoking and health "controversy." Such funding is often commingled with government grants. The tobacco industry also publicizes its funding of nontobacco research and various health charities, with the possible aim of enhancing its image.

Nowhere has the tobacco industry been more successful in creating a positive association with cigarettes than through sports sponsorship. Even from the onset of the ban on television cigarette promotion in 1971, tobacco brand-name sponsorship of televised sporting events became a more effective vehicle than overt cigarette advertising for reaching young viewers. Techniques such as placing billboards advertising cigarettes in baseball stadiums at locations frequently focused on by the television cameras and using tobacco brand-name logos on racing cars and drivers' uniforms have effectively undermined the intent of the broadcast ban on tobacco promotion, not to mention the low-budget antismoking education efforts

of government health agencies and voluntary organizations.

Smoking thus continues to go unrecognized by the public as the leading cause of preventable health problems, largely because cigarettes are the most heavily advertised US product. This advertising not only recruits new users but also buys the complacency of those who do not smoke. The tobacco pandemic is not a static concept, whereby information about adverse health effects is given on which individuals will act to change their behavior; rather, it is a dynamic concept, whereby the tobacco industry changes its strategies much like the AIDS virus alters its antigenic coat to outsmart the challenges of the host organism. The tobacco industry is a vibrant and dynamic force that researchers must monitor as they would a parasitic disease.

For example, as the consumption of cigarettes very slowly declines in the United States, American companies are dramatically expanding their markets in eastern Europe, Asia, Africa, and Central and South America. Thus, although public health organizations have long criticized government price supports for tobacco, comparatively little clamor has been raised toward ending US exports of cigarettes. Similarly, a disproportionate allocation of resources and personnel for smoking-cessation programs for adults by public health agencies and voluntary health organizations may have come at the expense of a concerted mass-media primary-prevention effort designed for young people.

TRAGEDY OF ETHNIC MARKETING

The age-old problems caused by tobacco in US society are dramatically worse in minority communities. The fact that cigarette smoking has become less fashionable among upper- and middle-income groups over the last decade may have lulled the public into believing that the United States is on its way to reducing the enormous toll taken by smoking. As the Task Force on Black and Minority Health of the Department of Health and Human Services pointed out in its 1985 report (6), there are substantial inequities in the health status of US ethnic and minority groups. The report noted that there are 58 000 excess deaths each year among black Americans compared with the death rate for the white population. Principal among the rising preventable causes of death are cardiovascular disease and lung cancer, the two major consequences of smoking (6). Blacks and Hispanics have the highest rates of these diseases in the US population, a fact that is obscured by a tendency in medicine to focus attention on the rare but highly publicized diseases that are more common in blacks than in others, eg, sickle-cell anemia (7). However, fewer than 300 of the 58 000 excess deaths among blacks each year are due to sickle-cell anemia and related blood conditions, a small fraction compared with the number of deaths attributable to smoking.

Those with the least income are spending the most on cigarettes—more than \$700/y to maintain a pack-a-day

habit. There is a constant presence of tobacco advertising on the news, sports, fashion, and life-style pages of newspapers and other publications directed at US blacks and Latinos. Tobacco companies have also become the major benefactors of black and Latino organizations, most of which continue to remain silent on the problem of tobacco use and promotion.

In many ethnic neighborhoods, as much as 80%-90% of all billboard advertising is for brands of tobacco and alcohol products (8). In black communities especially, cigarette advertising is the single common theme in various retail outlets from food stores and supermarkets to beauty parlors and barbershops (as well as dry cleaners, laundromats, gas stations, and bars and grills). Mass-transit systems, relied on more by lower-income commuters than by others, are an increasing showcase for cigarette advertising.

Because of their lower literacy rate, newer immigrant groups depend on television as their prime medium of communication and information. Taking advantage of this, tobacco companies have made an end run around the Public Health Cigarette Smoking Act of 1969 by getting cigarette brand names on various cultural and sporting events. Ironically, money-saving offers represent a major appeal by the tobacco industry to people with the lowest disposable income. There has been a dramatic increase in the number of rebate coupons in magazines and newspapers, good for substantial discounts on cartons of cigarettes. The free distribution of sample packs is also especially common in inner-city communities. The fact that a pack-a-day smoker will spend more than \$7000 in 10 years on cigarettes is not highlighted in tobacco company advertising.

The tobacco industry had been especially adept at exploiting racial identity in defining a profitable market among ethnic minorities. R.J. Reynolds sponsors Camel street fairs in Latino neighborhoods. Brown and Williamson presents annual Kool Achiever awards to people who have improved the "quality of life in inner-city communities"; the tobacco company has even enlisted the National Urban League, the National Newspaper Publishers Association, and the NAACP in the nominating process. During Black History Month each February, R.J. Reynolds has featured discount coupons in black-oriented magazines for various brands of cigarettes, complete with pictures of scientists such as George Washington Carver.

Publishers of newspapers and magazines with predominantly black readership who accept tobacco advertising are not reluctant, disinterested, or passive recipients of revenue from advertising that is intended to promote the use of a legal product in a free society. To the contrary, like their counterparts at *Time* and *Newsweek*, publishers of the minority-oriented press aggressively court tobacco advertisers by emphasizing their credibility and their reach in the community they purport to serve.

OFFICE-BASED STRATEGIES

Although many people say they have simply stopped smoking on their own, these individuals may not con-

sciously attribute their success to the increasing social pressures that reinforce their decision. Not only has organized medicine become united in the past few years on the need for more assertive office-based and community-wide strategies to end smoking, but other forces in society (eg, large corporations and government agencies) have also implemented smoke-free policies. The success of smoking-cessation programs for individual patients is likely to be dramatically enhanced in the presence of both workplace smoking bans and multimedia counteradvertising strategies that weaken the influence of the tobacco industry and reinforce the physician's office-based efforts.

Ideally, the validity of the success rate of a smoking-cessation method should rest on the results of a controlled double-blind study for which there is follow-up of at least 6 months' duration for all participating subjects. Few published outcome evaluations meet such criteria. Despite insufficient evidence to confirm advertising claims, expensive commercial aids and clinics for smoking cessation proliferate. Promotions for various pharmacological agents, mail-order gadgets, and clinics in smoking cessation reinforce the notion that cigarette smoking is primarily a medical problem with a simple, prescribable, 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.

The physician's active involvement in smoking cessation, similar to his or her role in the prevention of smoking among teenagers and children, can be crucial. More than a decade ago, when efforts to discourage smoking were much less widespread and accepted, Russell et al. (9) found that 1-2 minutes of simple but unequivocal advice to stop smoking on the part of the physician resulted in a cessation rate of over 5% measured at 1 year, versus only 0.3% in the control group.

Many factors may inhibit physician involvement in smoking cessation, eg, perceived or real lack of time, lack of reimbursement by third-party payers for such counseling, and lack of peer-group reinforcements in a technologically oriented, tertiary-care-centered health system. There is much the physician can do to become a better teacher in lieu of relegating this role to ancillary personnel or a smoking-cessation clinic or by handing the patient a pamphlet off the shelf. The physician can develop an innovative strategy beginning outside the hospital, clinic, or research center. A bus bench, billboard, or sign in the parking lot with a straightforward or humorous health-promotion message helps establish a thought-provoking and favorable image. In the waiting area, removal of ashtrays and the placement of signs noting that "in the interest of comfort, safety, and health, this is a smoke-free environment" further reinforce the message. Magazines with cigarette advertisements should not appear in the physician's office in the absence of prominent stickers or rubber-stamped messages calling patients' attention to the deceptive, absurd nature of this advertising. Physicians'

commitment to preventing their offices from becoming vehicles for cigarette sales would make a substantial contribution to health promotion.

The key to successful smoking-cessation efforts is a positive approach. A discussion about the diseases caused by smoking and the harmful constituents of tobacco smoke is essential, but the benefits of not smoking must be emphasized at least as strongly. Educating patients solely about the facts of smoking in a single office visit is unlikely to result in behavioral change. On the other hand, the physician can, by using creative analogies related to the patient's occupation, hobbies, or romantic interest, succeed in changing the patient's attitude toward smoking.

A revocabularization on the part of the physician is essential for making progress in office-based smoking cessation. Instead of *pack-year history*, a more relevant term is *inhalation count*. A patient who smokes one pack/d will inhale more than 1 million doses of cyanide, ammonia, carcinogens, and carbon monoxide in less than 15 years, not including the effects of inhaling other people's smoke. Another way to emphasize the enormous amount smoked is in financial terms: a pack-a-day cigarette buyer will spend in excess of \$700/y (calculated at approximately \$2.00/pack), which is in excess of \$8000/decade had that money been placed into a savings account or bond. One could also allude to the joyful feeling of finding a \$50 bill every few weeks—the amount that a smoker would save had the money not been spent on cigarettes. One patient who began smoking in the Marines at the age of 18 years, and who still smoked three packs/d at 33 years of age, ruefully remarked that he had “smoked a Porsche.”

Because patient education in general and smoking cessation in particular depend on the knowledge of both physician and patient of the deleterious aspects of adverse health behavior, the cognitive component alone is insufficient. Both physician and patient must be motivated to succeed.

The three keys to office-based smoking cessation are to personalize, individualize, and demythologize. 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 office materials in the way that a new drug or medical device would be evaluated. Personally handing a brochure to the patient while pointing out and underlining certain passages or illustrations will provide an important reinforcing message. Pamphlets, posters, and signs should be changed or updated frequently.

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 or symptoms of heart disease. In the case of a high school girl, the physician should not focus on abstract concepts (eg, emphysema and lung cancer) but rather the cosmetic unattractiveness of yellow teeth and bad breath, the loss of athletic ability, and the financial drain that results from buying cigarettes. For the male construction worker, the physician might suggest the likelihood of

fewer lost paydays, greater physical strength, and the possibility of a lengthier sex life were he to stop smoking cigarettes.

In the case of the concerned executive, it is especially important to demythologize certain beliefs about smoking, such as that the low-tar cigarettes are safer. The use of so-called low-tar brands, which should be referred to as “low poison” by the physician, may in fact result in compensatory deeper inhalation of greater concentrations of chemical additives and noxious gases that increase heart attack risk. One way to highlight the absurdity of the belief that low-tar cigarettes are safer is to ask rhetorically, “Safer than what, fresh air?” or to wonder aloud if it is safer to jump from the 90th story of the Empire State Building instead of from the roof. Another analogy is to point out that a person would never think of buying a loaf of bread, or any other consumer product, that was advertised as containing “only 2 mg of cancer causers.” Counseling should 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 ways in which brands are promoted.

COMBATING COMMON MYTHS

The saddest myth about smoking is that it relieves stress, which can be debunked by pointing out that the stress that is relieved is that resulting from cigarette dependence; this is the essence of addiction. The second saddest myth, reinforced in advertisements for Virginia Slims and a host of new lines of thin cigarettes intended for women and girls, is that smoking can keep them from gaining weight. Aside from calling attention to the many obese women who smoke and attempting to correct the misapprehension that being overweight is a greater health risk than smoking, the physician can point out that smoking inhibits appetite by damaging the taste buds and other digestive tract cells. Smoking also results in more sedentary behavior through loss of lung capacity and cardiovascular fitness. Weight gain does not have to accompany smoking cessation if patients relearn to enjoy walking and running; in short, by no means will all people who stop smoking gain weight. Even among those who do, the average weight gain is less than 5 lb (10). Moreover, the slightly lower weight of many who continue to smoke is associated with a higher-risk body fat distribution.

From the physician's standpoint, 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, patients who do not express an interest in stopping smoking symbolize the overall challenge that physicians face in curbing this pandemic. One reason for the lack of patient motivation may be a sense of inevitability of failure. It is conceivable that, by not educating the unmotivated smoking patient, the physician is in effect reinforcing the myth

that it may be too difficult to stop smoking. Setting a "quit date," the sine qua non of the smoking-cessation literature, may rationalize the continuation of an adverse health practice and may strengthen denial. In other words, it is helpful to remind patients that they can stop immediately.

CONSUMER ADVOCACY ROLE

Traditional office-based approaches begin by asking the patient if he or she smokes, how much he or she smokes, and when he or she started 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 he or she has no intention of stopping smoking. There are, however, alternative ways of obtaining information while piquing the patient's interest in the subject. By using and identifying with the vocabulary used by the cigarette consumer, the physician can adopt (and be perceived in) the role of consumer advocate, as opposed to medical finger wagger. The most important and non-threatening questions to ask are about the brands that are bought and how much is spent on cigarettes. Patients are likely to be surprised and intrigued by these apparently nonjudgmental questions, which can be asked at any time in the course of the interview. These questions suggest that the physician is not solely a know-it-all and a preacher on the dangers of tobacco use. In effect, a question about the cost of cigarettes shows concern for the patient's financial well-being. Inquiring as specifically as possible about the brand name, style, length, and package design—for example, Marlboro/Menthol/Lights/100s/box—will lead to a greater physician understanding of the same vocabulary used by the person who buys cigarettes, thus narrowing the communication gap. The patient may even begin to laugh aloud at the foolishness of this vocabulary, especially when he or she is encouraged to show the physician the package and to appreciate how little information about the product appears beyond the attractive design.

BEYOND THE EXAMINING ROOM

What specific measures can be used in planning strategies for preventing and ending the use and promotion of tobacco beyond the clinic? Foremost, there must be additional research, only a small part of which should be directed toward studying health habits, smoking-related disease incidence, and attitudes toward smoking. Health advocates must take the lead from tobacco companies and other purveyors of unhealthy products who have sought to overcome the burden of evidence of scientific research. A great deal can be learned by studying the techniques of the tobacco industry, which are in sharp contrast to those of health agencies. Health professionals need to conduct far more consumer research (eg, face-to-face surveys and in-store observations of buying habits) in lieu of health-behavior surveys.

To this end, school-based programs must be made more engaging (and enraging), placing an equal emphasis on what could be called the "three Ps": peer pressure, parental modeling, and propaganda. Curriculum designers for secondary schools should use a simple formula of fear, humor, and anger. 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. 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.

Because the onus for ridding society of tobacco and its promotion should not rest solely on parents, teachers, and health-care officials, reinforcement strategies must be created in health-care settings, religious and civic organizations, cultural and sports arenas, and the mass media. Health-care authorities and legal scholars have an ideal opportunity to combine forces in litigation by suing those who make and promote tobacco products. This includes seeking redress on behalf of those killed or injured in fires caused by cigarettes, which are designed to keep burning even when unattended.

The existing regional, national, and international coalitions to carry out a multilevel strategy toward ending the cigarette smoking pandemic are regrettably few. The necessary steps are not unidimensional; rather, they are multifocal and require concurrent strategies. Paid counteradvertising that ridicules specific tobacco brand names and advertising images is the most important force that will result in reduced consumption. So-called public service advertising space donated by media corporations to health agencies and other nonprofit groups is weak, bland, ineffectual, and seldom seen, because it is in effect controlled by the media. An excise tax dedicated solely to the purchase of counteradvertising space would be ideal, but this investment must be made even without such tax support.

In its only meaningful national test (between 1967 and 1970, when anticigarette commercials were shown 1500 times/y on television), counteradvertising had a greater effect in reducing smoking than the more frequently shown cigarette advertisements had in increasing cigarette sales. In the absence of memorable paid counteradvertising, the tobacco industry continues to run the year-round political-style campaign of an incumbent, with virtually no planned exposure by the opposition.

For health-promotion efforts to succeed by the year 2000, it will be essential to focus on the cigarette industry rather than on the behavior of individual cigarette smokers.

A ban on tobacco advertising and promotion is another ideal but lacks sufficient support from Congress and the president. On the other hand, enforcement by the US 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 completely tobacco-sponsored sporting events, levying fines of tens of millions of dollars per event (based on the hundreds of tobacco brand names shown on television during a tennis match or auto race), neither media corporations nor tobacco companies could afford to continue televising tobacco-sponsored sporting events.

As for the sports events themselves, cigarette sponsorships must be challenged not solely by attracting nontobacco sponsors but also by the frequent ridiculing of existing tobacco sponsors as a way of reinforcing the absurdity of associating smoking and athletic performance. A national organization, Doctors Ought to Care (DOC), was founded in 1977 to focus attention on the promotion of unhealthy products. 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. Since 1978, DOC has used its version of the Virginia Slims Tennis Tournament—the Emphysema Slims, with the slogan “You’ve coughed up long enough, baby”—to counter cigarette advertising. DOC convinced the 1988 US boomerang team, which was about to compete in the world championships in Australia with sponsorship money from Philip Morris Tobacco Company, to accept its sponsorship instead, complete with a uniform that featured the international nonsmoking symbol. For \$9000, DOC sent the team to Australia, where they won the world boomerang championship; afterward, many sportswriters cited DOC’s effort as a model for future sports sponsorship by health organizations.

The passage of smoke-free indoor legislation has been the single major advance in this country in terms of reducing cigarette consumption, thanks to the efforts of activist nonsmokers’ rights groups. Unfortunately, black and Hispanic membership in these organization is small, and the success of tobacco companies in influencing minority group lawmakers has been a major disgrace.

There is great need for a no-holds-barred revocabularization, ie, a new set of terms, images, and other symbols with which to communicate to the public about tobacco products and manufacturers. A crucial phase in US public health will be reached when the seven major tobacco companies in the United States are recognized as cancer’s seven 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 Barclay), American Brands (Carlton and Lucky Strike), Liggett and Meyers (generics), and UST (United States Tobacco Company: Skoal Bandits and Copenhagen spit-

ting tobaccos). Nor should it be underestimated that these are indeed primarily tobacco companies: although cigarette sales now account for approximately half the revenues of Philip Morris and RJR/Nabisco, they provide more than 70% of their profits.

To traditional public health workers, hard-hitting satirical counteradvertising that shifts public focus away from the substance (tobacco), the user (smoker), and the effects of the use of the substance (lung cancer) to the manufactured product, the way in which it is promoted, and the promoters may seem overly cynical and appears to risk incurring the wrath of the tobacco industry and its allies. This 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 successfully responded to thousands of research reports describing the dangers of smoking by funding hundreds more to seek further proof. However, although the health consequences may not be a deterrent, ridicule by consumers of the product, its promotion, and its promoters holds great potential for hurting cigarette profits.

A concerted effort that includes researchers, physicians, nurses, dentists, pharmacists, and all other health professionals is essential for ending the tobacco pandemic. All responsible citizens, health organizations, and corporations must be part of this effort to limit the promotional influence of tobacco companies.

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