

Cigarette smoking and ill health among black Americans

RICHARD COOPER, MD, BRIAN E. SIMMONS, MD

Cigarette smoking might be equally regarded as a symptom of a society at odds with itself or as a cause of disease per se; at either level, it has earned the reputation of public health enemy number one. Smoking is also a crucial example of how the health of the black population has worsened under the guise of social advancement. Blacks now suffer the highest rates of coronary heart disease (CHD) and lung cancer of any population group in this country.¹ This fact has been obscured by the tendency in medicine to focus attention on "typical" black diseases such as hemoglobinopathies and hypertension.

In 1977, there were 80,000 excess deaths among blacks, compared to the mortality rate for the rest of the population.¹ Yet the only clear-cut genetic disease of blacks known to contribute to this differential is sickle cell disease, and, in 1977, only 277 deaths among blacks were recorded as hemoglobinopathies, or 0.3% of the excess.¹ Environmental and social causes must be defined to explain the remaining 99.7%. The structure of the educational system, a discriminatory job market, and residential segregation have created a series of social relationships that confine blacks to a fixed position in society. The sum of these social institutions, reinforced by common attitudes and prejudices, generates the invisible chains of racial oppression. Although the specific causes of black ill health may change over time, the fact of the disadvantage is a constant and will remain so until the intensity of racial discrimination is reduced.

The cigarette industry has exploited racial divisions in defining a profitable black market. Specific brands, notably Kool (Brown & Williamson) and, to a lesser extent, Winston, More, and Salem (RJ Reynolds), Newport (Loews), and Virginia Slims (Philip Morris) have been promoted for maximum consumption in the black community through the black-owned press and by means of sponsorship of black civic organizations by tobacco companies. At the same time, black-oriented educational campaigns to discourage smoking have been limited.

PATTERNS OF CIGARETTE-RELATED DISEASE

Sources of data. It is difficult to arrive at precise estimates of the disease burden imposed by smoking on blacks. Long-term prospective studies of a sufficiently large and representative cohort would be required for direct estimates. Unfortunately, no such studies exist, and there are none currently underway. The major prospective studies of cardiovascular disease have never enrolled adequate numbers of black participants. Of the original 5,000 persons in the Framingham cohort, only six were black,²

and industry-based studies that were initiated at the same time did not include meaningful numbers of minority participants.³ A prospective study of smoking by the American Cancer Society enrolled 1 million participants, only 22,000 of whom were black.⁴ Two large randomized cardiovascular disease trials which were recently completed—the Multiple Risk Factor Intervention Trial (MRFIT) and the Hypertension Detection and Follow-Up Program (HDFP)—screened large numbers of blacks in the recruitment phase, and the follow-up data are now becoming available.^{5,6} All participants in MRFIT were men, however, and recruitment was aimed primarily at employed members of the middle class, resulting in a sample that is not representative of the black population. The cohort being followed in a prospective study by the National Health and Nutrition Examination Survey (of the National Center for Health Statistics, Hyattsville, MD) includes a more representative black sample, but one that also is limited in size (only 528 black men and 635 black women over the age of 25).

In the absence of survey data, it is necessary to rely on vital statistics. There are important limitations of the vital records system. In recent years, deaths have been coded by race, as opposed to the color system of "white" and "non-white." Although this may improve present data sources, it introduces problems of comparability when looking at trends over time. In addition, coding of death certificates is subject to misclassification in categories such as sudden coronary death. Lastly, as in all mortality studies, comparisons between populations reflect survivor effects as well as selection by competing cause. The survivor effect is best seen in the black-white crossover in old age.⁷ Thus, while fewer blacks live to the age of 80, those who do survive are healthier and suffer lower age-specific death rates than do whites. Since a larger proportion of the white population survives into old age, they will be more likely to die of the more common diseases of old age. The phenomenon of competing cause tends to eliminate potential candidates for a specific disease through premature death from another, related disease. Thus, if cigarettes contribute to both CHD and lung cancer, a population with a high rate of exposure to other risk factors (such as hypertension or elevated cholesterol level in the case of CHD, or industrial occupations in the case of lung cancer) might selectively lose high-risk individuals at a young age. A cigarette smoker dead of CHD at age 45 is no longer available to die of lung cancer at 50. Given the higher overall mortality of blacks compared to whites some distortions of cause-specific differentials will be observed. Unfortunately, there is no direct way to compensate for competing cause effects, and its true impact can only be a subject of speculation. One way to derive qualitative estimates of competing cause is to examine age-specific mortality patterns. While

From the Division of Cardiology, Department of Medicine, Cook County Hospital, Chicago.

Address correspondence to Dr Cooper, Associate Chairman, Division of Cardiology, Department of Medicine, Cook County Hospital, Chicago, IL 60612.

age-adjustment compensates for the differences in the age structure between the black and white populations, it still exaggerates the relative importance of the diseases of the very elderly, since a higher proportion of the white population dies in this age category. The practical significance of these problems will become apparent in the analysis of cigarette-related disease that follows.

Blacks have a six year shorter life expectancy and higher mortality rate from all but two of the 15 leading causes of death.¹ While violence and stroke are associated with higher relative rates among blacks, heart disease and cancer make up by far the largest contributions to excess black mortality, accounting for 30% of the increase in all causes of mortality for men and 40% for women. As the two major causes of death in this country and the major health consequences of smoking, heart disease and cancer will serve as the primary focus of this analysis.

Smoking patterns. Although surveys of cigarette use are subject to the bias of under-reporting, findings in numerous studies over a period of 40 years yield consistent conclusions.⁸ Blacks generally took up the smoking habit 10 to 20 years later than whites, in large part as a consequence of the mass migration from the rural South to the urban North.⁹ The first severely affected generation of blacks was that reaching young adulthood in the 1940s and 1950s. In the mid-1950s smoking rates for blacks were still lower than those for whites.⁸ During the past 20 years the racial patterns of smoking have remained static, with parallel changes in both groups. The percentages of adult smokers have leveled off at about 45% for black men and 30% for women (Table I). Despite the higher preva-

TABLE I. Smoking Rates by Age, Sex, and Race; US, 1965 and 1980

	Percentage Current Smokers			
	1965		1980	
	White	Black	White	Black
Men				
All ages ≥ 20	52.1	59.6	37.1	44.9
25-34	60.7	68.4	42.0	52.0
35-44	58.2	67.3	42.4	44.2
45-64	51.9	57.9	40.0	48.8
≥ 65	28.5	36.4	16.6	27.9
Women				
All ages ≥ 20	34.5	32.7	30.0	30.6
25-34	43.4	47.8	31.6	43.2
35-44	43.9	42.8	35.6	36.5
45-64	32.7	25.7	30.6	34.3
≥ 65	9.8	7.1	17.4	9.4

Source: National Health Interview Survey (18, p 365)

lance of cigarette users among black men, numerous reports have shown that black smokers use fewer cigarettes per day. Thus, while 37% of white male smokers reported use of 25 or more cigarettes per day in 1980, only 11% of black men smoked that heavily. Among women, 26% of the white women smoked 25 or more cigarettes daily, compared to 10% of black women.¹⁰ Age patterns of smoking are similar in women in the two races, yet among young black men there is a higher prevalence of cigarette

use.¹⁰ In sum, taking into account both the prevalence of smoking and the number of cigarettes consumed per smoker, it seems reasonable to conclude that as a population black women smoke 10% to 20% less than white women, while black and white men consume similar amounts of tobacco. These estimates do not take into consideration other factors such as differences in degree of inhalation, length to which the cigarette is smoked, the age at which smoking began, and brand preferences.

Coronary heart disease. There is a common misconception among physicians that blacks are relatively immune to CHD. The reasons for this belief are complex, based on such divergent causes as the reputation of CHD as a disease of affluence and the higher levels of high density lipoprotein cholesterol reported among blacks.¹¹ Although CHD rates appear to have been lower in blacks than whites for a decade or so after World War II,^{12,13} they are slightly higher at the present time. Based on the 1981 vital statistics, age-adjusted mortality for CHD (both sexes combined) among blacks was 144 per 100,000, versus 133 for whites.¹ Two recent symposia have debated at length the epidemiology of CHD among blacks.¹⁴ The data are inconsistent, particularly in relation to men, and additional population-based prospective studies are needed. The most recent age-sex-race specific data for CHD are presented in Table II. Age-adjusted

TABLE II. Age-Specific Death Rates from Coronary Heart Disease, by Sex and Race, US, 1978 (per 100,000)

Age (yrs)	Men		Women	
	White	Black	White	Black
35-44	57.8	97.7	10.7	38.1
45-54	253.4	335.9	54.1	159.3
55-64	713.7	846.3	216.9	446.4
65-74	1,654.5	1,568.3	717.1	1,039.3
74-85	3,939.5	3,341.2	2,505.2	2,608.3
85+	7,597.7	4,024.6	6,246.0	3,463.1
All ages, age-adjusted	257.8	260.6	117.2	159.7

Source: Health: United States, 1981, pp 124-127.

rates are virtually the same for black men, compared to white, while they are 36% higher for black women. The phenomenon of an age crossover is apparent among men, with rates 50% higher in the age range 35 to 44 years for blacks, but higher for whites above 65. Only the much larger proportion of deaths among whites above age 80 make the age-adjusted rate similar in men. Among women, a crossover is seen at age 80, with rates over 85 being twice as high for white women.

Why should a population with high rates of disease in middle age become resistant as it grows older? No intrinsic biologic explanation for this phenomenon exists. In a period of rapid secular trends, it is possible that rates could be going down for whites overall, while moving in the opposite direction for blacks. The younger generation would thus represent a new high risk group; as this generation ages it would continue to experience higher rates, and, eventually, the differential would be consistent at all

ages. In fact, the racial crossover is not a transient phenomenon but one that has existed in some form for many years. In addition, secular trends in CHD have paralleled each other in the two racial groups for the last 15 years, declining rapidly in both.¹³ The most likely explanation of the crossover is a combination of the healthy survivor effect and competing cause. Blacks at high risk for CHD, namely those who smoke or have another, related disease, such as hypertension, are more likely to die before reaching the age of 80 than are whites.⁷ Loss of these individuals from the cohort would falsely reduce the importance of the underlying process of coronary arteriosclerosis.

Direct evidence exists to support the argument that competing cause reduces apparent CHD rates. In the follow-up data from MRFIT, blacks had slightly lower rates of CHD, yet, as expected, they experienced a proportionately higher mortality from stroke.⁵ CHD death rates were 4.6/1,000 for black men, and 5.2/1,000 for whites, while stroke mortality was 1.3/1,000 for blacks and 0.5/1,000 for whites. More important, given the prospective nature of these data, it could be demonstrated that the deficit of blacks dying from CHD occurred exclusively in the hypertensive group. It was this group that contributed to the excess number of deaths from stroke in blacks. It seems likely that many black men who are prone to coronary disease because of hypertension as well as cigarette use, are dying from stroke, renal disease, and heart failure before they have a chance to become a victim of CHD.

There has long been concern that death certification may be less reliable for blacks than for whites, and may have biased the vital statistics. A new longitudinal study of cardiovascular disease (Community and Cohort Surveillance Program) has been organized by the National Institutes of Health and will allow more precise study of mortality patterns.¹⁵ Data from the pilot phase of the study indicated the following age-adjusted rates per 1,000 persons of fatal CHD: black men = 3.12, white men = 2.77; black women = 1.37, white women = 1.00.¹⁵ Although both incidence and mortality appear to be higher at younger ages, the black disadvantage persists in the age-adjusted mortality data. However, these rates are based on relatively few events, and only after completion of this study will there be definitive evidence.

In summary, CHD remains the most common cause of death in the black population, accounting for more than 20% of all mortality. Despite the popular misconception, it

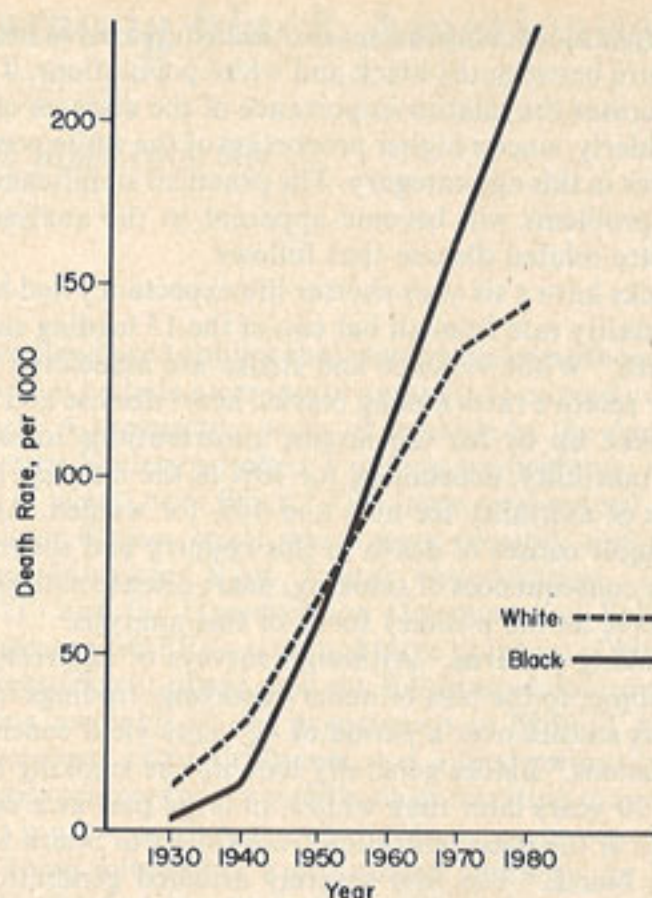


FIGURE 1. Death rates from lung cancer for men, black and white, ages 45 to 64, US, 1930-1980.

occurs more frequently among blacks than whites. The increase in risk of CHD associated with cigarette smoking is the same in blacks and whites.⁵ Cigarette smoking has been estimated to account for one third of all CHD deaths,¹⁰ and doubles the relative risk of CHD among individuals with hypertension. Widespread smoking has accelerated the development of atherosclerosis in the black population.

Lung Cancer. When the rise in the incidence of primary lung tumors was first recognized in the 1930s, the death rates among blacks were about half of those of whites. Since then there has been an enormous increase in lung cancer in the black population (Table III, Fig 1). Rates among both black and white women have accelerated since 1950. A racial age crossover in lung cancer is seen for both sexes (Table IV).

The rate of rise for men from 1950 has been three times greater for blacks than whites, and in the "maximally affected cohort"—the generation with the highest age-spe-

TABLE III. Respiratory Cancer Death Rates, Men, White and Non-White, US, 1930-1980 (per 100,000)

Age-Race Group	Year						% Increase 1950-1980
	1930	1940	1950	1960	1970	1980	
White							
45-54	8	20	35	54	68	75	+133
55-64	13	41	85	152	199	214	+152
Non-White							
45-54	3	15	34	72	113	148	+335
55-64	6	20	69	159	232	340	+393

Source: US Vital Statistics Yearbooks, selected years; *Health: United States, 1981*, pp 132-133.

TABLE IV. Age-Specific Respiratory Cancer Death Rate by Sex and Race, US, 1978 (per 100,000)

Age (yr)	Men		Women	
	White	Black	White	Black
35-44	11.7	26.8	7.0	8.6
45-54	75.0	147.6	32.7	41.6
55-64	214.4	339.7	69.9	68.5
65-74	407.5	439.5	90.5	70.3
75-84	510.7	493.6	91.4	92.0
85+	359.3	215.4	77.6	50.8
All ages, age-adjusted	57.4	79.1	16.8	16.0

Source: *Health: United States, 1981*, pp 132-134.

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Cigarette ads account for in excess of 12% of total advertising in *Essence*, "The magazine for today's black woman" (top left). Apart from alcohol advertising (20%), cigarettes are the leading product category in the magazine. Among advertisers tying in to Black History Month in February 1985 was RJ Reynolds, which marked the occasion in *Essence* with a discount coupon good for \$1.50 off a carton of Salem (bottom left). The advertisement also featured the headline "A Salute to Black Scientists and Inventors" and a portrait of George W. Carver. Other advertisers in each issue of *Essence*, *Jet*, *Ebony* and other black-oriented publications include Brown & Williamson's Kool (bottom center) and Loews' Newport (bottom right). Since 1981 Philip Morris has published *A Guide to Black Organizations*, replete with cigarette advertisements featuring black models, which is distributed to black politicians and other leaders (top right). In the introduction to the 1983 edition, Philip Morris chairman Hugh Cullman wrote that the "directory's purpose is to illustrate for Blacks—and for all Americans—how much can be done when people work together in the name of progress and prosperity."

cific rates—mortality is more than twice as high. Age-adjusted rates for men are now almost 40% higher among blacks. Although the rate of increase has begun to slow for white men, the exponential increase continues among blacks, and the peak cannot be predicted.

The sharp upturn in lung cancer among blacks in the 1950s is consistent with the 20-year latency period expected from other population studies of cigarette use, given the increase in smoking among blacks during World War II. As noted above, however, blacks did not smoke more than whites overall at this time and certainly not in the 20-year period before 1960. The higher lung cancer rates cannot therefore be explained entirely by smoking. On the other hand, if racial susceptibility were important, a higher rate among black women (as compared to white women) would be expected.¹⁶ It has also been noted that much of the black-white difference in lung cancer can be eliminated with control for social class.¹⁷ It is possible that this class and race difference is mediated in part by other known risk factors for lung cancer, such as occupational exposures, low vitamin A intake, and inner-city residence. At the present time no direct data are available to assess the relative impact of these various causative factors. Whatever the mix of risk factors, it is clear that the introduction of smoking into this population has created a public health crisis.

Bronchitis and emphysema. Little has been written on the question of chronic obstructive pulmonary disease (COPD) in the black population. Based on vital statistics, blacks of both sexes have lower rates than whites.¹ Classification of deaths under this code began only recently, however, and adequate time trends are not available. Because COPD is a less frequent cause of death and is related to CHD and cancer by virtue of the common cause of smoking, interpretation of these data is further complicated by the problem of competing cause.

CAUSE AND CURE

In a disease-based analysis, the foregoing discussion has attempted to outline the impact of the cigarette on the health of the black population in the United States. Although the health consequences of smoking extend well beyond CHD and lung cancer, these disease categories subsume the majority of cigarette-related deaths and demonstrate the epidemiologic patterns. As noted at the outset, however, from the point of view of the etiology of this epidemic, smoking should be conceived of as a mediating factor—a proximate, not an ultimate, cause. Tobacco use is a social phenomenon and can be best understood only through an analysis of the relationships between people and institutions within that society. Approximately \$30 billion per year is currently spent on tobacco products; about \$6 billion in profits return to the cigarette industry, \$6 billion to the government in taxes, and varying lesser amounts to a host of advertising agencies, retail stores, and farming interests. It is no secret that maintaining the flow of these profits has been the social purpose for which 360,000 persons a year die due to cigarette-related disease in this country. Cigarette smoking now displays a sharp class gradient, being concentrated among the working class and the poor of both races (Table V). Extracting profit by this means has proven to be an effective adjunct

TABLE V. Age-adjusted Percentages of Current Smokers by Education, White and Black Men, 1970-1975 and 1975-1981

Year	White		Black	
	High School	College	High School	College
1970-75	48%	36	59	56
1976-81	37%	24	57	45

Source: Wynder EL, Goodman MT: Smoking and lung cancer: some unresolved issues. *Epidemiol Rev* 1984; 5:190.

to the overall process of exploitation at work in contemporary American society. The basic causes of the cigarette-disease epidemic among blacks are, therefore, the same as the causes in the rest of the population.

There is no likelihood of effective cures for smoking-related diseases. Prevention requires the removal of tobacco, obstacles to which are too difficult to surmount in an economic system based on production for profit. The only realistic hope for prevention, under these circumstances, lies in broadening the gains made against smoking among the educated and privileged to include the working class and minority groups. Considering all the other health threats to black Americans, there is a most urgent need to sound the alarm about the compound ill effects of smoking (and the pernicious and pervasive influence of tobacco companies), especially by those who occupy positions of respect in the black community. Finally, there is ample evidence that doctors can change smoking habits of patients. Approximately 25% of patients will stop permanently at the urging of their physician, making this approach perhaps the single most potent means of influencing individual behavior.¹⁸ Within the medical community, greater awareness of the problem of CHD and lung cancer among blacks is needed, and this must be translated into increased anti-smoking efforts.

The black-white health differential remains because little is done about it. The gains that followed on the heels of the civil rights movement and the urban rebellions of the 1960s and 1970s could be measured in improved health.¹⁹ Despite a temporary reduction of racial inequality, the opposite trend has returned. Income among blacks was half that of whites until 1950; although the ratio rose to 0.61 in 1970, it has fallen back once again.²⁰ The widening gap in black-white infant mortality suggests a parallel outcome for health.²¹ Institutional racism is an indispensable pillar of American society; without it current profit levels could not be maintained and capital would suffer enormous dislocation. At the same time, to take a serious view of this problem requires acceptance of the conclusion that inequality must no longer persist. Just as the ongoing power of the tobacco industry makes a mockery of any claim that the business community and government put the health of the nation above all other interests,¹⁰ so the excess price in health demanded of the black population belies any claim that racism does not lie at the core of American society.

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CIGARETTE COMPANIES GO TO COLLEGE

On July 25, 1984 the Fortieth Anniversary Gala of the United Negro College Fund (UNCF), representing 43 private, predominantly black colleges, was held in New York City at the world headquarters of Philip Morris, makers of Marlboro and other cigarettes, Miller beer, and 7-Up soda. Hugh Cullman, chairman and chief executive officer of Philip Morris, is a member of the UNCF Board of Directors and served as co-chairman of the 1984 corporate campaign for the UNCF along with the president and chief executive officer of Time, Inc.

On the afternoon of the reception, Christopher Edley, executive director of the UNCF, was asked by the editor of the *Journal*, Alan Blum, MD, if the organization had ever questioned the morality of the acceptance of money from a cigarette producer in light of the disproportionately high rate of lung cancer among blacks.

"This is the first time I've heard of it [the moral issue]. Philip Morris gave to black colleges long before there was a cancer scare. In the case of RJ Reynolds* and Philip Morris, they are located right in the heart of [regions with] black colleges. Philip Morris was originally a Richmond, Virginia company. The Cullman family is largely identified with black colleges. Let's face it. They have p.r. problems they did not have many years ago. Sure they know there's a double purpose to be painted as good guys. But take RJ Reynolds. They've diversified. I'm not even sure a majority of their profits are from tobacco. . . .

"I don't make those strong moral judgments. . . We have been more troubled by [funding from] alcohol [companies] because some of our schools are sponsored by religious denominations."

Asked if he were aware that Philip Morris holds nearly half of the South African cigarette maker, Rothmans, Edley responded, "I'm not surprised. Ford, IBM, and lots of companies that give to us have investments in South Africa. During the civil rights struggle and the rigid segregation against blacks in the South, you never heard anyone in the North saying don't buy from certain companies [that acquiesced in discriminatory policies]. So now we reach 6000 miles across the ocean and speak with impunity. . . .

"We get several hundred thousand dollars a year from cigarette companies. I am not about to lead a crusade to get that money removed. . . .

"It may be 50 years from now, or even 25 years from now when we will look closer to our contributors and question some of them, but for now we won't turn down a reception or a donation."

—Editor

* According to *The Charlotte Observer*, Nov 12, 1984, RJ Reynolds marked the 40th anniversary of the UNCF by donating a \$250,000 ruby-and-diamond necklace from Tiffany & Co rather than money, as part of the tradition of giving rubies on 40th anniversaries. Actress Ruby Dee made the presentation in Chicago on November 10, 1984 during the intermission of the Ebony Fashion Fair. In 1983 Reynolds pledged \$1 million to the UNCF over four years, and the necklace represented the second installment. Overall in 1984 UNCF sought \$28 million, including \$10 million from corporations.