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Commentary

Medicine vs Madison Avenue

Fighting Smoke With Smoke

ALL PHYSICIANS—and increasing numbers of the general public—recognize the link between cigarette smoking and emphysema, squamous cell carcinoma of the lung, chronic bronchitis, cardiovascular problems, low birth weight, and other disabilities. However, few people realize that the tobacco industry has always tried to associate cigarette smoking with *good* health. And those who look on cigarette smoking as an inalienable right find it hard to believe that it is not even a time-honored tradition.

Even well into the 1920s, cigarette smoking still had little appeal—and definitely not to women—but through advertising, the tobacco companies thought they would be among the very first to give women one version of equal rights: "To keep a slender figure, no one can deny . . . Reach for a Lucky instead of a sweet." A well-promoted aura of romance and sophistication made smoking Camels synonymous with being "a social success," and dozens of movie stars were used as models in the advertisements.

But we have also been asked to consider our health as well as our looks. Children learned from reading the Sunday funnies that smoking Camels could give them "healthy nerves," "a flow of energy," "relief from fatigue," and "better digestion." Baseball stars like Lou Gehrig and Joe DiMaggio endorsed Camels ("Athletes smoke as many as they please"), and even Santa Claus found Lucky Strikes "easy on my throat." During World War II, advertising made a carton of cigarettes the ideal gift for the boys overseas, a fact any physician working in a Veterans Administration hospital during the past 30 years could confirm.

And how did the tobacco industry respond to the reports in the 1940s and 1950s that associated cigarette smoking with a variety of chronic and lethal ailments? It stepped up its promotion, and on the back of most issues of *TIME* or *LIFE*, R. J. Reynolds could proclaim, "MORE DOCTORS SMOKE CAMELS THAN ANY OTHER CIGARETTE." Even in *JAMA*, until well into the 1950s, the hucksters would dare to say, "If pleasure's your aim, not medical claims, light an Old Gold," and "Why many leading nose and throat specialists suggest . . . Change to Philip Morris." Physicians were taught their ABCs—"Always Buy Chesterfields." The P. Lorillard Co incurred the wrath of the American Medical Association by implying that Kent had been proven to provide "health protection." Commercial messages appeared not just in print but on almost all major radio and television programs, including prime-time news broadcasts. The purpose of such advertising was not just to sell cigarettes but also to promote the social acceptability of smoking.

Plus ça change . . .

Sadly, the situation is unchanged. The tobacco industry continues to run a year-round, essentially unopposed campaign ($800 million annually vs less than $1 million in government public service announcements and pamphlets) in newspapers, magazines, supermarkets, and pharmacies. Almost half of all billboard advertising is for cigarettes, and every child grows up seeing thousands of these larger-than-life commercials—with the Surgeon General's warning neatly camouflaged.

Although publishers reject some advertising such as X-rated movies, they employ the First Amendment to explain that any attempt on their part to tone down the health or sex appeal in cigarette advertisements would be censorship. Those who call for greater scrutiny are portrayed as seeking prohibition. Today, let physicians suggest a connection between cigarette smoking and high health costs or fire loss or decreased worker productivity, and they are branded as "anti-smokers." Yet the tobacco advertisers somehow escape the sobriquet "anti-health."

In claiming that it does not approve of young people smoking, the tobacco industry offers "peer pressure, parental smoking, and a climate of general rebelliousness among teenagers" as the reasons for adolescents taking up the nation's number one form of drug abuse. Unlike the alcohol distillers, the cigarette manufacturers have never taken out a single advertisement to discourage young people from using their product. To the contrary, they have increased their youth-oriented music and sports promotions. Cash incentives to smoke cigarettes—in the form of discount coupons in the Sunday magazine, sports, and food sections of newspapers, not to mention the free samples handed out by attractive young ladies on street corners—have increased 1,000% in the last five years.

Since most, if not all, new customers come from the 8- to 21-year-old age group, who could doubt that the tobacco industry has not carefully researched this market? Peer pressure can be bought, as any rock music impressario, toy maker, or market research expert will corroborate. Of the ten most heavily promoted products in America, five are

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cigarette brands—the ones smoked most by teenagers.

Despite an advertising blitzkrieg second to none and few financial and social disincentives for an adolescent to take up smoking, the tobacco industry would have the public believe that adolescents have heard "the facts" about "both sides" and now have a "free choice" to decide whether or not to smoke "when they grow up."

The Physician's Role

It seems that the individual physician, confronting such a propaganda barrage, would be powerless to combat the epidemic of cigarette smoking. But there is much a physician can do to become a better teacher and "prevention specialist," in lieu of relegating the health education role to ancillary personnel, a smoking cessation clinic, or a pamphlet off the shelf. The physician can develop an innovative strategy beginning right in the office or clinic waiting area. What positive health incentives now greet the patient? Ashtrays? Magazines with dozens of cigarette advertisements? A commitment on the part of American physicians not to let their offices be vehicles for selling cigarettes would make a substantial contribution to health promotion.

The physician can learn to personalize approaches to patient education by carefully scrutinizing every pamphlet and audiovisual aid in the office. It is essential that he be as critical of patient education materials—be they slick booklets distributed by pharmaceutical companies, brochures from medical associations, government pamphlets, or posters from the voluntary health agencies like the American Lung Association—as of any medical device, drug, or expensive piece of office equipment.

Should the physician be using the same cigarette counseling method with a high school girl, a strapping blue collar worker, and an executive already showing symptoms of heart disease? In the first instance, should the physician be talking about such abstract concepts as lung cancer or emphysema? Might it not be better to emphasize the physical unattractiveness of stained teeth, bad breath, the loss of athletic ability, and the financial drain that can result from buying cigarettes? Might we suggest to the blue collar worker the likelihood of fewer days lost from work, greater athletic prowess, and even a lengthier sex life were he to "kick the cigs"? And might it not be better to point out to the concerned executive that a so-called low tar cigarette may in fact contain higher concentrations of chemical additives, carbon monoxide, and other gases and thus increase the risk of heart attack? In any case, such dialogue must be practiced over and over again and individualized to the patient; it should be designed so as 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 way in which it is promoted.

As the AMA Council on Scientific Affairs report on smoking implies (p 779) in its call for more vigorous efforts on the part of the medical profession, physicians can extend their health promotion and prevention-oriented efforts beyond their offices, for they are in a position to have a considerable impact on their communities and, in turn, on society at large. Active participation in school health education programs—more often than not dull and scanty—is needed. Following the lead of Charles F. Tate, Jr, MD, of Miami, physicians can become more involved with local health initiatives such as clean indoor air acts for airports and other public gathering places. They might also join a coalition of physicians, medical students, and other health professionals called DOC (Doctors Ought to Care), which has launched a novel health promotion effort in several states aimed at curbing such lethal life-styles as cigarette smoking, alcohol dependence, other drug abuse, poor nutrition, and teenage pregnancy.

What's up, DOC?

One of the key components of DOC's SuperHealth 2000 approach, in addition to setting up speakers bureaus of local health professionals and involving teenagers themselves in the design of projects, has been a counteradvertising campaign directed at junior high school students, which employs *paid* radio and television commercials, posters, newspaper and bus bench advertisements, and T-shirts. DOC has found that humor can be an effective tool. In one of its poster series, DOC parodies the classic "I smoke for taste" advertisement with a picture of a similarly defiant, macho character with a cigarette dangling from one nostril and the caption, "I smoke for smell." One bus bench advertisement, which on first glance looks like it is selling cigarettes, proclaims, "10 YEAR SUPPLY ONLY $7,000."

Support for continued visible counteradvertising of this kind is urgently needed. The most dramatic decline in cigarette sales occurred between 1968 and 1970, the only period when cigarette advertising and counteradvertising (by the voluntary health agencies) coexisted on television. Moreover, the counteradvertisements were mostly shown in off-hours and in a very small ratio compared with the prime-time Marlboro men. In 1970, when televised cigarette advertising was "banned" by Congress—at the behest of the tobacco industry, alarmed at the success of counteradvertising among adolescents—the sales of cigarettes resumed an upward course.

Emphasis on the physical effects of cigarette smoking has not been shown to be the most appropriate way to tackle the adolescent cigarette epidemic. Cigarette advertising can keep up with the latest fads in its portrayal of smoking and so remain "with it" far better than the lugubriously developed and fleetingly tried run of "anti-smoking" programs.

An investment on the part of organized medicine is needed in the primary prevention realm and not just in smoking cessation "kits." A statement from "Childish Habit," an editorial in THE JOURNAL of Sept 14, 1964, is equally true today: "Reduction or elimination of cigarette smoking can be achieved only if today's nonsmokers never start." It is time medical science made it easier for itself by catching up to advertising science in communication skills.

Just as the 1960s were a time of political consciousness-raising, so the 1980s could become an age of enlightenment as physicians help to educate the public not only about the preventable factors responsible for bad health and high medical costs but also about the insidiousness of the outright promotion of those factors.

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