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1947 R.J. Reynold's Camel advertisement featuring Rudolf Virchow. This was published in the New York Journal of Medicine as part of a series on great medical scientists.

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EDITORIAL

Sleeping with the Enemy: "More Doctors Smoke Camels" Revisited

Matthew R. Anderson, MD, MS

In this issue of *Social Medicine* we offer readers two classic papers on tobacco activism which originally appeared in the *New York State Journal of Medicine* in 1983.[1;2] These papers are introduced by Dr. Alan Blum who was editor of the journal at the time.

In one of classic papers – "When 'More doctors smoked Camels': Cigarette Advertising in the *Journal*" Dr. Blum examines efforts by the tobacco industry to associate itself with doctors and make various "health claims" for their cigarettes. This practice was denounced by the Journal as early as 1927. In a commentary published in the *New York State Journal of Medicine* the Medical Society of New York's legal counsel Lloyd Paul Stryker noted:

> *When [...] non-therapeutic agents such as cigarettes are advertised as having the recommendation of the medical profession, the public is thereby led to believe that some real scientific inquiry has been instituted, and that the endorsement is the result of painstaking and accurate inquiry as to the merits of the product.*[3]

Editors at the *Journal* felt strongly enough about this issue to publish guidelines requiring that advertisements "would be edited as if they were scientific articles or news items." Despite these policies, Dr. Blum carefully documents the long, tragicomical string of tobacco ads that graced the pages of the journal from 1933 until 1955. From the vantage of 1983, Dr. Blum comments:

> *Thirty years after cigarette advertisements disappeared from peer-reviewed medical journals, it seems inconceivable that they ever could have been accepted in the first place.*[1]

It is easy to look back and see the folly of our predecessors, but what might they be saying about us thirty years hence? In this editorial I would like to examine the modern equivalents of cigarette advertising and their connections with several of our most important medical associations: the American Academy of Pediatrics (AAP), the American Academy of Family Practice (AAFP), and the American Medical Association (AMA).

The American Academy of Pediatrics and Advertising for Baby Formula

The health benefits of breast-feeding for both mother and child have been amply documented in the medical literature and are generally accepted.[4] The importance of breastfeeding was recognized by its inclusion among the goals of Healthy People 2010, a set of leading public health indicators guiding actions by the US government. Unfortunately, US rates of breast-feeding lag dramatically behind those of the rest of the world. As of 2005, only 21% of US women were still breastfeeding at one year post-partum; the Healthy People 2010 goal is 25%.[5]

Why do less than a quarter of US women continue breastfeeding at a year post-partum? At least part the answer lies in the fact that breast milk substitutes are widely advertised and promoted in the United States. This is not true of other countries. Most countries – but not the US – have adopted the 1981 WHO International Code of Marketing of Breast-Milk Substitutes. The Code is explicit that: "There should be no advertising or other form of promotion to the general public of products within the scope of this Code."

In 2005 the Section on Breastfeeding of the American Academy of Pediatrics issued a strong endorsement of breastfeeding in a widely quoted position paper published in *Pediatrics*.[4] In line with

the Code, the AAP position paper notes that "commercial promotion of infant formula through distribution of hospital discharge packs, coupons for free or discounted formula, and some television and general magazine advertising" are obstacles to breastfeeding. It goes on to call for the elimination of "promotion of infant formula in hospitals including infant formula discharge packs and formula discount coupons." Curiously, among the many recommendations in the position paper there is one striking omission. The AAP does not suggest that the International Code be adopted in the US nor that the advertisement of breast-milk substitutes to the general public be banned.

This omission is particularly troubling because the Academy is not a neutral party in this matter. It has economic ties to the makers of breast-milk substitutes. Perhaps the most visible of these ties is the support of Abbott Nutrition for *Pediatrics in Review*, the Academy's flagship CME (continuing medical education) publication for physicians, as well as for NeoReviews.org, the AAP neonatology review website; Abbott Nutrition is the maker of the Similac line of baby formula. This means that readers of *Pediatrics in Review* will see the Abbott name and logo each month with their CME materials. Visitors to the *Pediatrics in Review* or NeoReviews.org website will also see the Abbott name and logo. These routine reminders of the ties between the Academy and the makers of Similac are in direct contradiction to the AAP position paper which calls for a culture in which breast-feeding is presented as a cultural norm. In fact, the association of the AAP and the Abbott logo provides exactly the opposite message by reinforcing the normalcy of infant formula feeding.

Of greater concern is the Academy's endorsement of what amounts to a Babys "R" Us sales catalog entitled: "Becoming Us: A Comprehensive Resource Guide for Getting Ready for Baby."[6] When we perused this resource guide online in late May 2010, we found pictures of Similac, Enfamil, Good Start, & Earth's Best infant formulas (each hyperlinked to more extensive advertisement) as well as what looks to be a candy for toddlers (Plum Organics Fiddlesticks). On page 3 of the Babys "R" Us guide we read:

> *The editorial content of this resource guide has been reviewed for consistency with the health & safety recommendations of the American Academy of Pediatrics. Special thanks for reviewing the guide go to: Laura A. Jana, MD, FAAP & Jennifer Shu, MD, FAAP, authors of Heading Home with Your Newborn: From Birth to Reality. Copies of this award-winning AAP parenting book are available for purchase at select Babys "R" Us stores, bookstores nationwide and at HealthyChildren.org, the new AAP Website for parents.*

It is troublesome that the Academy puts its endorsement on what is essentially an infomercial for the baby products industry. It is concerning that the "comprehensive resource guide" is all about buying products, presenting this as the essence of preparing for a new baby. But the Academy's endorsement of advertising materials which include breast-milk substitutes seems to violate the essence of their position paper as well as what we know to be best for mothers and children.

The American Academy of Family Medicine and Coca Cola

Not to be outdone by the AAP and its partnership with Babys "R" Us, the American Academy of Family Physicians (AAFP) announced last October that it had formed a corporate partnership with Coca-Cola, Inc. The purpose of the partnership was "to develop consumer education content related to beverages and sweeteners for the AAFP's award-winning consumer health and wellness Web site, FamilyDoctor.org. [...] The content will address sugar-free alternatives to help patients make better choices."[7] Although not mentioned in the announcement, anyone visiting FamilyDoctor.org will see at the very top of the webpage the red and white logo of the "Live Positively" Coca Cola campaign. It sits alongside the logo of Nature Made, a manufacturer of "vitamins, supplements, and multi-vitamins."

If you happen to visit the page on sugar substitutes there is a most curious mixture of messages.[8] On the left there are several paragraphs of plain text written by the AAFP on sugar

substitutes. Immediately to the right is a colorful ad from the Live Positively campaign. It has the same red and white logo, now with Coca Cola explicitly named. The ad offers "the truth about low-calorie sweeteners right here." It contains five tabs and a downloadable full color PDF brochure with pictures of happy, thin young people and all Coca Cola products using sugar substitutes. The contrast between the plain-text AAFP materials and the full color Coke brochure could not be greater.

When Coca Cola offers us the "truth about low-calorie sweeteners," we are left with a set of disturbing questions. Does the fact that Coca-Cola is a corporate partner publishing an ad on the AAFP website mean that the truth in the ad is something endorsed by the AAFP? What role has corporate "partner" Coca-Cola played in the text that the AAFP has printed next to the ad? Who is defining the truth and why? Whatever the answer, an important rule in dealing with corporations is *caveat emptor*.

Given the obesity epidemic in the US and the prominent role played by soft drinks in that epidemic, many family physicians were outraged by the AAFP's decision to partner with Coke. The California Academy of Family Physicians pressed the national Academy to rescind this partnership arguing that it went counter to the Academy's efforts to fight obesity and diminished the Academy's credibility.[9] Nonetheless, the national Board refused to change its mind. Without defending the specific decision to partner with Coca Cola, the Board argued that: "The Consumer Alliance program is consistent with the mission, vision and values of the AAFP which have been developed by AAFP members over many years." [10] How can this possibly be true?

However, the real issue is almost certainly not the website. Rather it is the battle over imposing a sweetened beverage tax. This tax has been supported by the California Academy and vehemently opposed by the soft drink beverage industry. Providing funding to the AAFP may be one strategy employed by Coke to neutralize a very potent potential adversary in this battle.

As with the smoking advertisements in the *Journal*, such "corporate partnerships" provide some semblance of health legitimacy for an industry that has done much to harm public health.

The American Medical Association and Big Pharma

Our final contemporary case concerns the AMA and its support for pharmaceutical efforts to promote brand name medicines. It is a complex story and let us begin by considering why generics might be a good choice for patients.

Generics typically offer a number of advantages over brand-name medications. Most importantly, there is no evidence generics are clinically inferior to brand name drugs*[11] and they often cost dramatically less. Many of the new brand-name drugs are simply "me too" reformulations or slight variants of old drugs that offer no real clinical advantage.[12] It is not uncommon for unexpected problems to emerge when a new drug is taken by hundreds of thousands of people; these problems might not be detected in smaller clinical trials.

To overcome these disadvantages the pharmaceutical industry needs to aggressively market new drugs to doctors who are the ones doing the actual prescribing. In order to better target and prepare their sales staff, the pharmaceutical companies rely on a process called "data mining."[13;14] Data mining occurs when information on individual prescriptions is transmitted to the pharmaceutical sales staff in real time. This information transfer involves three commercial transactions all of which happen out of the sight of both patient and doctor. Here is how it works.

The process begins with the sale of prescription information by pharmacies to large companies called Health Information Organizations (HIO's). This information does not – in theory – provide identifying information about the patient but does provide information about the doctor such as license or DEA number. In order to identify the individual doctor, the HIO cross references the information supplied by the pharmacy with the AMA Physician Masterfile, a list of some 820,000 medical school

* For some medications consistent blood levels are very important and it may be preferable to take pills coming from only from one manufacturer. Prescribing a brand medication may be appropriate in these cases.

graduates. This is a second commercial transaction since the AMA sells access to the Physician Masterfile. By comparing pharmacy sales information with the Masterfile, the HIO can identify which physician wrote the prescription. In the third commercial transaction the prescription data is sold to the pharmaceutical company. All this occurs in real time so that the pharmaceutical sales person knows right away who on his or her beat is prescribing what. Sales staff boast that they know more about what doctors prescribe than the doctors themselves and this seems credible.[13]

Most physicians are aware that when they write a prescription that information is being sold by large corporations and used for marketing purposes. But most object to this information being shared with pharmaceutical representatives. To deal with these concerns the AMA has created an "opt out" program in which individual physicians can chose to limit what information is sold to the pharmaceutical company. Oddly enough, the (misleadingly named) opt-out program does not prevent the pharmaceutical company from purchasing individual physician data. Pharmaceutical companies are only prevented from sharing the data with local sales staff. Who enforces their compliance with this agreement? No one. The pharmaceutical companies are supposed to police themselves.

Given physician concerns and the strong arguments in favor of generics, why would the AMA collaborate in this way with the HIO's? The answer is almost certainly financial. In 2005 the AMA received $44.5 million for the sale of the Masterfile, amounting about 16% of its revenue.[14]

As is the case of AAFP and Coca Cola, the dispute over the Physician Masterfile has larger political dimensions. A number of states have either passed or are considering laws that would significantly limit data-mining. Neutralizing the AMA in this matter is of obvious importance to the HIO's and Big Pharma.

Making sense

The AAP, AAFP, and AMA are large professional organizations with important financial ties with much larger for-profit corporations. In exchange for financial support they have been willing to allow their name (AAP, AAFP) or databases (AMA) to be used in the promotion and legitimization of products that may not be in the best health interests of the people they are supposed to serve. Similar concerns have been raised about the APHA, the American Public Health Association.[15] We presume that these actions do not reflect the values of their membership. It is legitimate to ask, therefore, if we have really progressed from the time when cigarettes were advertised in medical journals under the slogan "more doctors smoke Camels."

It is possible to see these cases as individual examples of moral lapses on the part of venal and self-serving individuals lured by the easy money of corporate "partnership." But to view these as individual failings obscures the larger pattern and leads us away from a systemic analysis. Pulling our lens back, we see that these associations have become the captives of corporations which serve their profession. Rather than working for their patients or their members, they are promoting the ends of the corporations. Another, less generous, interpretation is that the organizational needs of the associations have become more important than the health needs of the people they nominally serve.

Rather than asking "how is this possible" the real question is "how could it be otherwise" in a society so dominated by large corporations? The contest between association and corporate partner seems entirely unfair given the relatively small size and resource base of the associations and the vast wealth commanded by corporate biomedicine. The $44.5 million given to the AMA for the Masterfile is drop in the bucket for a pharmaceutical industry that spent nearly $16 billion promoting drugs in the US in 2000.[13] Yet that $44.5 million is 16% of the AMA budget. It is not hard to see how the leaders of the professional organizations come to accept the corporate logic and convince themselves that Coca Cola (with its deep, deep pockets) is a legitimate partner in patient education materials about beverages.

Of course, physicians are not simply the hapless dupes of large corporations. The leaders of these organizations really should know better. But by virtue of their social background and professional training physicians are not radicals accustomed to

standing up to big institutions. On the contrary, most have been socialized into a culture where accepting gifts and meals from pharmaceutical companies is seen as the usual way to conduct business.

What can be done?

First, it is important to appreciate that there is a progressive wing within medicine that has opposed the corporate agenda. Dr. Blum's articles remind us of physician activism in the struggle (as yet unfinished) against big tobacco. The actions of the California Academy of Family Physicians should be praised and supported. Among their many excellent initiatives, the National Physicians Alliance (NPA), a relatively new physicians' organization set up by former members of AMSA, has made data-mining one of its key areas of advocacy.

Secondly, we have allies outside of the physician community. There is a strong, international movement and strong institutional support for breast feeding (e.g. by UNICEF). There are many legislators around United States who would like to see a sweetened beverage tax as well as curbs on data-mining. Both measures make clear public health sense and would serve to bring down health costs.

Finally, we should look to the larger anti-corporate movement in the US and abroad. The pharmaceutical industry and agribusiness are under attack by governments, other professional organizations, and by popular movements. In our own backyard here in the Bronx, there are many local initiatives to rethink how we produce and consume food. The challenge for us is to link these various forces into an effective movement.

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Smoking and the *New York State Journal of Medicine*: a brief introduction

Alan Blum, MD

2010 marks the 25th anniversary of the publication by the *New York State Journal of Medicine* of the second of two theme issues on the world tobacco pandemic, the first comprehensive examination of the subject ever published by a medical journal. Aiming to challenge the medical profession to become actively involved in fighting smoking, the issues went beyond a discussion of the well-known health consequences of tobacco to a consideration of the social, political, economic, agricultural, religious, and legal aspects of this growing problem.

The *Journal* spared no institution, including organized medicine. One article, "When 'More Doctors Smoked Camels,'" reprinted in this issue of *Social Medicine*, recounted the history of acceptance of cigarette advertising and conference sponsorship by the Medical Society of the State of New York (as well as the American Medical Association and virtually all state medical societies) from the 1930s to the mid-1950s in spite of mounting evidence about the irredeemable harmfulness of smoking. The *Journal* also exposed the hypocrisy of *The New York Times* for its refusal to address the ethical conflict of soliciting cigarette advertising while rejecting ads for a variety of other legal products like guns and X-rated movies. Not until 1999 did *The Times* stop accepting tobacco ads, sidestepping the question of what made smoking more of a public health threat in 1999 than it had been a half-century earlier.

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Among the more than 100 other original articles in the two theme issues was the first major review of cigarette smoking's contribution to ill health among African Americans, with a focus on the ubiquitous target-marketing of this group by the tobacco industry. In a tabulation of the economic impact of the tobacco industry in all 50 states, the *Journal* identified strong commercial ties between the tobacco industry and the pharmaceutical industry which made many of the chemicals used in cigarette manufacture. The headquarters of four major cigarette manufacturers were located in New York, making it the international capital of the tobacco industry. New York was also the home of many of the tobacco industry's advertising and public relations agencies, as well as the major television networks, such as CBS, which was owned by Loews, which also owned Lorillard Tobacco. Although cigarette advertising was banned from television and radio by Congress in 1971, the *Journal* described how tobacco companies remained leading sponsors on TV, continuing to wield influence on the news divisions, through the acquisition of food subsidiaries. RJ Reynolds took over Nabisco, and Philip Morris bought Kraft and General Foods. The same advertising and public relations firms in turn also represented the pharmaceutical industry, which played no role at all in public health efforts to reduce tobacco-caused diseases until some companies began marketing nicotine replacement products in the 1980s.

Smallpox, cholera, polio, and many other scourges have been conquered in this country. There even have been significant advances in treat-

Image Source: http://blumarchive.org/center.php

ing AIDS. But the smoking epidemic has continued to smolder, killing hundreds of thousands of Americans a year. The inability to deliver a knock-out blow to the tobacco industry as a vector of death and disease represents the worst public-health failure in history. The number of US consumers who smoke is not substantially below that in 1964, and the cohort of users is as young as ever.

It didn't have to be this way. The tobacco pandemic had been cultivated in plain sight for most of the century. My own inspiration to take on tobacco came from my late father, Leon Blum, MD, a general practitioner in Rockaway Beach, New York. When we watched Brooklyn Dodgers baseball games together in the 1950s, he was upset that one of the sponsors was Lucky Strike cigarettes. Predicting that one day no one would possibly believe that smoking could ever have been promoted through sports, he urged me to tape record the between-innings cigarette commercials, preserve the sports magazines, and write about tobacco as editor of my high school newspaper in 1964, the year the first Surgeon General's report was released.

By the time I entered Emory University School of Medicine in the early 1970s, I assumed that I would be in a health care environment in which everyone would be taking up the charge of the Surgeon General's report and actively fighting tobacco use and promotion. Nothing could have been further from the truth. In my own education, I heard only one lecture in four years that focused primarily on tobacco: a presentation on pulmonary disability by Dr. Brigitte Nahmias. But, by including an image of an attractive cigarette ad in her talk followed by a photograph of a patient with emphysema, she gave me an idea to create an archive of tobacco advertising, out of which I developed my own presentations juxtaposing tobacco advertising and tobacco-related diseases. By the end of medical school, I was giving talks to my colleagues and in local schools, and in 1977 I started DOC (Doctors Ought to Care) in an effort to unite medical students and physicians in tackling the tobacco pandemic and other lethal lifestyles in the clinic, classroom, and community.

In 1977 DOC became the first organization to purchase satirical counter-advertising space in newspapers, on radio, on bus benches, and on billboards aimed squarely at the tobacco industry and its brand-name products. The funding came from membership donations from medical students, residents, and practicing physicians, and for its 25 years of existence DOC was one of the few such self-sustaining health advocacy organizations. DOC, which established more than 150 chapters in medical schools and residency programs in all 50 states, drew support from more than 5000 physicians and medical students, convened the US's first youth conference on tobacco in Miami in 1978. It led the first street protests (which we named "housecalls") to ridicule tobacco promotions such as the Virginia Slims Cigarettes Tennis Tournament, which we renamed the Emphysema Slims. DOC's contribution to public health was to shift the focus away from nicotine, the smoker, and lung cancer, and instead onto the source of the problem: the tobacco industry.

DOC was a volunteer, extra-curricular effort. To this day, medical schools and schools of public health have done a poor job of teaching about tobacco. What is still urgently needed, in my opinion, are engaging, longitudinal, continuity-of-care experiences in lifestyles education and behavior modification of patients by medical students beginning in their first year and continuing in each phase of medical school and residency training. Astonishingly, for all the lip service paid to the toll taken by tobacco, such a curricular component does not yet exist at a single medical school. The result is that residents and upper level medical students know a decent amount about even rare cardiovascular conditions but next to nothing about enhancing patients' ability to stop smoking, to lose weight, to exercise, or even to relax.

Outspoken opponents of smoking and the tobacco industry, such as thoracic surgeon Dr. Alton Ochsner, who had attempted to call public and professional attention to the rise in smoking-induced lung cancer beginning in the 1930s, and John Banzhaf, a lawyer who was responsible for getting the Federal Communications Commission to mandate antismoking commercials on TV and who founded Action on Smoking and Health in 1968, have been few and far between.

I believe my own persistent opposition to the tobacco industry was unsettling to many in medical

academia, They feared the tobacco industry's political clout could jeopardize NIH research grants and plans for medical school expansion. the *Journal's* second tobacco theme issue received widespread national news coverage, a laudatory editorial in *The Lancet*, and hundreds of requests by physicians and health organizations for additional copies. Yet five months after its publication, I was dismissed without notice as editor of the *New York State Journal of Medicine*. I was also fired by an interim director of the Medical Society, a relic of an era of political deal-making in smoke-filled rooms, such as the decades-long alliance between the American Medical Association (AMA) and tobacco state Congressmen to protect doctors' economic interests in exchange for doing nothing against tobacco. When I joined the faculty at Baylor College of Medicine in 1987, I was urged to leave my tobacco activism behind and "get into something more socially acceptable, like cocaine." I had a similar bizarre experience in 1988 when after being named editor of *American Family Physician*, the journal of the American Academy of Family Physicians, I was offered a contract that explicitly forbade me from speaking publicly on smoking for a minimum period of one year. The Academy, which was still accepting lucrative advertising and conference support from the food subsidiaries of RJ Reynolds and Philip Morris, was not yet willing to confront the cigarette makers. I turned down the job.

Because of the paucity of fearless leaders in tobacco control, the tobacco industry has remained in the driver's seat throughout the nearly five decades since the Surgeon General's report. Seven years elapsed, for instance, before Congress banned cigarette advertisements from the airwaves (1971), and then only at the behest of the tobacco companies which had seen sales flatten as the result of the first wave of antismoking commercials between 1967 and 1970. Not until more than two decades after the report, and only after the first large studies implicating passive smoking as a cause of lung cancer in non-smokers had withstood a heavy assault by cigarette companies, were the first strict clean indoor air laws passed by a handful of cities. Airline flight attendants, the personification of canaries in the mine, battled for nearly 25 years to end smoking aloft, finally succeeding in 1988.

Meanwhile, the well-funded voluntary health agencies have lagged behind, especially considering their enormous annual tax-deductable income. Virtually every major health group and government agency from the American Heart Association and American Cancer Society (ACS) in the private sector to the National Cancer Institute (NCI) and the Food and Drug Administration (FDA) in the public sector has had to be shamed into taking a stronger position against tobacco use and promotion. Consider the ACS's one-day-a-year Great American Smoke-Out, which has devolved into a commercial promotion for stop-smoking medications. It is long past due to give the tobacco industry one day a year to push smoking, and let anti-smoking forces have the other 364. Although tobaccogenic disease accounts for upwards of 40% of all cancer deaths, it is unconscionable that the American Cancer Society allocates only a few million dollars of its $1 billion annual income to reduce smoking, not the $400 million a year it ought to be spending. Similarly, federal government efforts for the most part have been muted and uninspired, with the rare exception of the persistent campaign of Surgeon General Koop in the 1980s and hard-hitting comments by government officials like Joseph Califano, Louis Sullivan, and David Kessler in the 1970s, 1980s, and 1990s, respectively.

Following the release of the landmark Surgeon General's report on smoking and health in 1964, the AMA, which was the lone health organization to withhold its immediate endorsement, accepted $18 million from the tobacco industry to conduct research on smoking that added little to the evidence already amassed but served to delay its involvement in speaking out against tobacco for nearly a generation. Well into the 1980s, the AMA was known more for its silence on smoking than for its courage, as exemplified by a September 7, 1982 memorandum from the editor of *JAMA* warning his editorial staff to "exercise appropriate caution in our *JAMA* publications on tobacco and control of tobacco use, nuclear war, and abortion." In providing this "preventive advice" he noted that "sensitivities here are particularly high prior to the meetings of the Board of Trustees and the Annual and Interim Meetings of the House of Delegates."

Progress has come about so slowly because of a

combination of political clout and lucrative payoffs to the very forces that should have been in the vanguard to end the tobacco pandemic. Congress (Republicans and Democrats alike), the mass media, organized medicine, and academia have all been chronic recipients of largesse from the tobacco industry, and have not been prepared to bite the hand that fed them. Meanwhile, the health community has carried on, bouncing from one failed multimillion dollar public-relations crusade to another and putting its faith in mirages such as safer cigarettes, a cash settlement with the tobacco industry, and federal legislation aimed at regulating tobacco products.

For the past half-century, virtually all reports of diseases caused by smoking were disputed by the tobacco industry, which claimed that more research was needed (which it was only too happy to fund). Only in 1999, confronting massive litigation, did Philip Morris acknowledge "the overwhelming medical and scientific consensus that cigarette smoking causes lung cancer, heart disease, emphysema, and other serious diseases in smokers." Meanwhile, as millions died from cigarette smoking, research funded by the tobacco industry resulted in a plethora of filters, "low-tar" products, and "light" or "ultra-light" brands, none of which made cigarettes any safer. Such machinations led to the finding by Federal Judge Gladys Kessler in 2006 that the company had violated civil racketeering laws over a 50-year period by deceiving the public about the dangers of smoking.

History has shown that the tobacco industry has outwitted public health advocates at every attempt to impose federal tobacco legislation. By breaking ranks with the rest of the tobacco industry in 2001 to support FDA regulation of cigarettes Philip Morris scored a major public relations coup by portraying itself as no longer part of the problem but rather part of the solution. The very fact that the nation's largest cigarette manufacturer supported this legislation should have created skepticism that the bill would be sufficient to curb the tobacco pandemic and should have prompted concern that, once again, health groups had been outsmarted.

The new FDA tobacco agency will stringently regulate new and potentially less hazardous products, such as the electronic cigarette, but was hamstrung by Congress in applying the same regulatory standards to the most irredeemably harmful form of tobacco, current cigarettes like Marlboro, which cause the deaths of nearly half a million Americans each year.

Tobacco companies have also outmaneuvered health advocates who believe they had found a way to use the industry's money to fund antismoking education. The Master Settlement Agreement between the state attorneys general and the tobacco industry in 1998 did lead to hundreds of millions of dollars for the newly created American Legacy Foundation and major multimedia counteradvertising campaigns aimed at reducing demand for tobacco. However, the aftermath of the Settlement became less about fighting tobacco than about fighting over grants to fight tobacco. Sadly, the Master Settlement Agreement of 1998 has resulted in a tiny fraction—2.6%—of settlement funding being directed toward smoking prevention and cessation programs. Only four states allocate to tobacco prevention the minimum amount recommended by the Centers for Disease Control and Prevention.

Had the American Legacy Foundation (and the State of California and the Robert Wood Johnson Foundation, the two previous major funders of antitobacco activities in the 1990s) devoted the better part of its resources to mass media campaigns instead of to research, conferences, and analysis of industry documents, then we would have greatly enhanced the chances of reducing tobacco consumption by the time legislation to regulate the industry came into effect. Instead, the major focus of efforts since the Settlement has been on the passage of federal legislation to bring tobacco under the control of the FDA , which will now become, in the absence of sufficient remaining funds for mass media, the primary vehicle for reducing demand. No government agency can reduce demand for tobacco by fiat.

Rather than training more nicotine addictionologists and tobacco control policy experts, we need to cultivate innovative grassroots activists and steadfast troublemakers. In other words, we need less research, more outspokenness, and more action. It may still be possible to turn the past century's greatest public health failure into a triumph in this one.

Cigarette smoking and its promotion: Editorials are not enough*

Alan Blum, MD

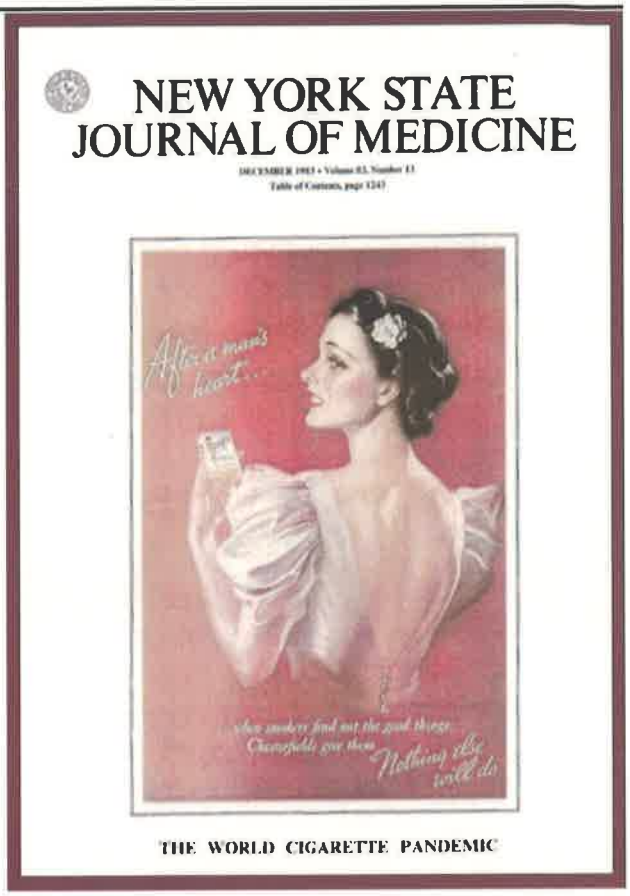
One man's death is another man's living.
Ira Gershwin

This issue of the *Journal* marks the 20th anniversary of the first report on smoking and health by the Surgeon General of the United States Public Health Service. Preparations for the issue began one year ago with a letter to the present Surgeon General, C. Everett Koop, MD, requesting an interview on the subject of juvenile-onset cigarette smoking. Dr Koop's encouraging reply inspired other letters to individuals around the world who have been deeply committed to ending the cigarette pandemic.

Luther Terry, MD, one of those continuously involved during the last 20 years in seeking solutions to the smoking problem, supported the idea of an entire issue on the subject of the world cigarette pandemic. In his behind-the-scenes account in this issue of the origins of the 1964 report, Dr Terry describes the meticulous attention to objectivity exercised by his advisory committee and notes the efforts by the tobacco industry to cast doubt upon the findings. He credits his predecessor, Leroy E. Burney, MD, for a courageous policy statement in 1957 that left little doubt about the relationship between cigarette smoking and cancer of the lung. Each succeeding Surgeon General has been committed to curbing the use of tobacco. This issue of the *Journal* marks the first time that all Surgeons General who have spoken or written on the hazards of smoking have contributed to a single work on the subject.

In July in Winnipeg, Canada, at the Fifth World Conference on Smoking and Health (held at four-year intervals since 1967), the *Journal* invited several principal speakers to participate in this issue. Just as Sir George Godber, former chief medical officer of England, challenged his audience in Winnipeg to ask, "How many more such conferences is the world condemned to need?" so he urges the reader of this issue to become more actively involved in efforts to counteract smoking and its promotion. There are hopeful signs, he noted, in such disparate activities as Finland's North Karelia cardiovascular disease prevention project and Australia's BUGA-UP (Billboard Utilizing Graffitists Against Unhealthy Promotions).

Of all the sessions at the five-day conference, the most ominous—and least well-attended—were those



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that examined current efforts of the tobacco industry to open new markets and increase the level of smoking in developing nations. Not only does this portend a health catastrophe akin to that which has occurred in industrialized countries but also a more immediate ecologic threat due to the mass destruction of trees used for flue-curing of tobacco. Several papers in this issue examine the tobacco dilemma of the Third World. Mike Muller's analysis of economic, social, and agricultural aspects of the situation leaves little doubt that the sole beneficiaries in the long run are the multinational tobacco companies. Profiles of four countries—Nigeria, Malaysia, India, and Brazil—offer a depressing scenario in which local health authorities seem powerless. An economic analyst, Frederick Clairmonte, DSc, believes that the first step toward finding a solution lies in looking not at the health consequences of smoking but rather at the interconnecting boards of directors of industry and banking, which he feels create obstacles to the provision of economic disincentives for the sale and cultivation of tobacco. Moreover, although the major cigarette manufacturers have dropped the word "tobacco" from their names in most instances and have diversified (ostensibly as the result of health concerns about tobacco), cigarette sales remain the number one profit maker for these companies. Dr Clairmonte points out that the tobacco industry is becoming synonymous with the selling of alcohol, and he raises the possibility that pharmaceutical research may be influenced by considerations of the cigarette industry. Indeed, it was noted in Winnipeg, the president of one of the largest pharmaceutical companies serves on the board of a major tobacco company, and advertising accounts for many pharmaceutical products are held by advertising agencies that also promote various brands of cigarettes.

The most chilling realization of all is that the world headquarters of the cigarette industry lies not in the Deep South, but in New York City. New York is home to three of the six American cigarette manufacturers and the site of offices of two others. Nearly all of the advertising agencies that promote the products and objectives of the cigarette companies are located in New York. Most tobacco industry publications, including *The United States Tobacco Journal* (which became *The United States Tobacco and Candy Journal* earlier this year), are published in New York. The Council for Tobacco Research, which awards industry-financed grants for medical investigations, is based here.

In addition to hosting the headquarters of the three major broadcasting networks, New York is also home to one of the world's most influential newspapers. For more than a decade, several physicians, most notably George Gitlitz, MD, have challenged *The New York Times* to recognize the irony of repeated editorial accusations of financial self-interest on the part of the medical profession by acknowledging the newspaper's own role in promoting the major preventable cause of illness and avoidable medical costs. An eight-year correspondence between Dr Gitlitz and *The Times* is published in this issue, and the newspaper's rationalizations can only be read with disbelief.

At a time when newspaper editorialists across America are calling for greater accountability of physicians, it is dismaying that any editor or publisher can continue to defend the mass media's acceptance of cigarette advertising. Lest the position of a privately owned publication in a free society be misunderstood, there is no obligation to accept cigarette advertising merely because the product being sold is "legal." *The Times'* editorial opposition to teenage cigarette smoking and other forms of drug abuse is an insufficient rationalization for the newspaper's acquiescence in the promotion of cigarettes. Even the tobacco companies claim they do not approve of children smoking. The success of advertising campaigns for cigarette brands can be measured not only in terms of the continued high sales among young people in the face of all consequences but also in the continued complacency of editors and publishers who refuse to admit the connection between promoting cigarettes and the high economic and physical toll taken by smoking.

In recent years the mass media have played an increasing role both in reporting on health issues and also in determining the course of medical research. As the result of a news story on a puzzling disease, a threat to community health, or a laboratory finding, public pressure can be brought to bear on government to allocate additional funding for a line of research. If backed by the right publicity and the right people, a disease may even wind up with its own special institute at the National Institutes of Health. And whatever the disease, there is a presumption, fed by the mass media, that the key to better health lies in the research laboratory. According to the media, all carcinogens are equal—except that some carcinogens such as formaldehyde, asbestos, and dioxin (but not the carcinogens in cigarette smoke) are more equal than others. Coverage of Surgeon General Koop's statement that 170,000 Americans will die in 1983 due to smoking-related heart disease was confined to a wire service article on page D18 of *The Times*, while hearings on formaldehyde received greater attention in the main news section. The media claim that they are only reflecting the direction of modern medicine, and—publishers' and advertisers' concerns about coverage of smoking notwithstanding—they may have a point. One

has only to read a fundraising letter sent in September 1983 by a major cancer treatment center to understand how far prevention nihilism has gone:

> *Last year in your home state of New York, 9,000 people died of lung cancer.*
>
> *Perhaps someone you know—a loved one or a friend—has lung cancer. It's quite possible, because this disease is the most common form of cancer, and one of the most difficult to control. ...*
>
> *But some cancers—like lung cancer—do not respond well to existing forms of treatment. And because of this we must find new and different approaches for treating these difficult cancers. This is our goal, and we need your support to reach it.*
>
> *Because research efforts are so important, I want to ask you to consider making a generous gift .... You see, there are so many potential areas of research. So many new approaches we must try. But for that we need sufficient funds ....*

The mass media are also reflecting the state of medical publishing in taking their cues for stories to cover. Because of the increasingly specialized nature of medical journals, smoking is considered only piecemeal, if at all, depending on the specialty. The pharmacotherapeutic objectives of controlled-circulation and single-sponsor publications have left little space for articles on preventive issues. One suspects that smoking may not be considered intellectually important enough: How often is smoking the topic of grand rounds? There may even be concern that those who propose such a conference might be carrying on a crusade—as if a campaign against an epidemic is something undignified or inappropriate. How, too, does one explain the reply of an editor of a national medical journal to a professor of public health in which a manuscript is rated "excellent, and a sure bet for a public health journal" but cannot be published in the general medical journal "because we've recently run an article on smoking"? Or the comment of another editor of a major medical journal which seldom publishes articles on the topic: "Saw your piece on cigarette advertising. Oh, I wrote that kind of thing 15 years ago." Apart from *The Lancet*, *The British Medical Journal*, *The American Journal of Public Health*, and a few journals in respiratory diseases and preventive medicine, smoking is seldom addressed.

This issue, then, challenges preconceptions, not the least of which is that cigarette smoking is a moralistic topic. To believe this is to believe that suffering is a matter of informed consent, because an obscure and wordy warning has been placed in fine print on cigarette advertisements for the past 15 years. The key word to describe this issue is "context." Any textbook of pathology or public health can provide the grim details of the damage due to smoking. This issue attempts to place the subject in a variety of contexts, some of which most physicians may not have considered in depth—especially the man-in-the-street context of advertising. Medical training is geared almost exclusively to individual treatment and diagnosis. Very little of this issue is directed toward the cessation of smoking and the plethora of stop-smoking gimmicks, none of which has been shown to be as effective as the words and compassion of the physician himself or herself.

The intent of this issue is to go beyond the posters, pamphlets, and palaver to the realm of primary prevention of the three million adolescents who take up smoking every year in this country. The term "peer pressure" is invoked in hand-wringing fashion to explain the seemingly insoluble dilemma of teenage self-destructiveness, while the *billions* of dollars spent on cigarette and alcohol advertising each year in the United States is seldom considered as the neglected cornerstone of drug abuse. Denial of our national drug abuse problem has become a cliché; but what is there to say when the major nationally televised program on adolescent drug abuse, "The Chemical People," contained not a single mention of smoking or of advertising for alcohol and cigarettes? (This in spite of a report issued earlier this year by the director of the National Institute on Drug Abuse, William Pollin, MD, indicting cigarette smoking as America's leading form of drug dependence.)

Because labels such as "antismoking," "smoker," "nonsmoker," "quitter," and "addict" may well have hampered a dispassionate analysis of the smoking problem on both individual and societal levels, contributors to this issue were encouraged to challenge the conventional vocabulary of smoking. Insofar as the average physician is concerned, smoking cessation has been regarded largely—if regarded at all—as a frustrating, futile, or hit-or-miss matter with little scientific basis. Not one of the nearly 9,000 continuing medical education courses offered in the United States in 1983 was devoted to scrutiny of methods for the treatment of the problem recognized by the World Health Organization and the Centers for Disease Control as the single most preventable cause of poor health in the world. One of the objectives of this issue is to encourage physicians to realize that not all of the onus for solving the smoking pandemic lies with themselves or with researchers or with governments—or, for that matter, with patients. But it is imperative that physicians overcome the misapprehension that patients "have heard it all before," for most informa-

tion about smoking perceived on a day-to-day basis by the public and the medical profession alike has been put to them in the form of $1.5 billion worth of advertising images each year. As W. R. Rickert, PhD, implies in this issue, by advertising cigarettes as "low tar" (low poison? fewer carcinogen-containing compounds per puff?), the tobacco industry has become our leading health educator. At the very least—whether through the introduction of "toasting" in the 1920s, filters in the 1950s, or less "tar" in the 1970s, the industry has succeeded in allaying the health concerns about smoking on the part of millions of Americans and in undermining educational efforts—unimaginative, off-the-mark, and poorly promoted though most such campaigns may be—about the undeniable and irredeemably harmful consequences of cigarette smoking. The motto of the tobacco industry could well be "ubiquity, propinquity, iniquity," for it is by posting its cigarette brand images everywhere, by juxtaposing the images to enjoyable and healthful activities such as sport, and by reinforcing a sinful, rebellious idea of smoking that it keeps sales high.

Since the mass media will not report on the subject of cigarette smoking and its promotion to the extent that they cover even the rarest of diseases, physicians must choose whether to adapt to the mass media's concept of health and disease or to act on the basis of their own knowledge. Is it not our duty to work as hard to end the world cigarette pandemic as those who are paid to glorify the image of smoking?

ALAN BLUM, MD
Editor

When "More doctors smoked Camels": Cigarette advertising in the *Journal**

Alan Blum, MD

Even well into the twentieth century, cigarette smoking hadn't caught on among most men—and definitely not among women. But through mass media advertising and overseas tobacco funds for the boys at war, cigarettes became firmly entrenched by the 1920s. The tobacco companies were the first to offer women equal rights, of a sort, with slogans such as "I'm a Lucky girl," "Blow some my way," and "Do you inhale? Everybody's doing it!" Readers of the Sunday funnies were told by ballplayers like Lou Gehrig and Joe DiMaggio, "They don't get your wind ... So mild, athletes smoke as many as they please!" To respond to those nagging, fuddy-duddy health doubters, various salutary claims and endorsements by doctors of certain brands began to appear. By the 1930s cigarette advertisements had made their way into medical journals, including the New York State Journal of Medicine. *The following article was written by Alan Blum MD, Editor, with extensive research assistance by Jessica Rosenberg, a medical student at New York University.*

In 1927 the American Tobacco Company began a new advertising campaign for the nation's leading cigarette brand, Lucky Strike, by claiming that 11,105 physicians endorsed Luckies as "less irritating to sensitive or tender throats than any other cigarettes." The reaction in the *New York State Journal of Medicine* was a swift denunciation from both a moral and a scientific standpoint by the Society's legal counsel, Lloyd Paul Stryker:

> *In this present era of advertising and publicity ... we are accustomed to see portrayals of dramatic critics, actors, and others smoking some particular brand of cigarette and certifying that there is nothing like it. The endorsers, we understand, are not infrequently remunerated.*
>
> *The propriety of this course on the part of those who furnish their endorsements, where such endorsers are members of the laity, is a matter falling within their liberty of choice, and is properly governed by their own sense of fitness of things. When, however, non-therapeutic agents such as cigarettes are advertised as having the recommendation of the medical profession, the public is thereby led to believe that some real scientific inquiry has been instituted, and that the endorsement is the result of painstaking and accurate inquiry as to the merits of the product.*
>
> *Despite the frequent attacks upon the medical profession, we believe that the people of this country take them as a whole, have a regard and wholesome faith in their physicians. All that tends to the building up and strengthening of this faith redounds to the benefit of the medical profession and of its individual members, and that which in any wise tends to shake this faith and confidence works a detriment not only to the profession as a whole but to each individual practitioner. All that tends lo strengthen the faith of the people in the belief that medical*

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opinions are founded upon a sound scientific basis, should be fostered by the profcssion.[1]

Although Stryker could find no canon of the principles of professional conduct of MSSNY* that such endorsements definitely violated, he questioned whether or not such involvement by physicians, albeit in this instance most likely unintentional, tends "to advance the science and honor of medicine and to guard and uphold its high standard of honor."

A few months later the *Journal* noted the praise by *California and Western Medicine* (among other journals) for Stryker's commentary:

It is regrettable that any physicians should have thoughtlessly lent their support to this advertising scheme. The profession that has studiously worked to protect the people from fraudulent claims of drug advertisers should be more alert and discerning.[2]

In the same issue, the *Journal* published new Advertising Standards that declared, "The *Journal* will continue to select, to require proof, to reflect. And its advertising columns will prove increasingly valuable to the readers as a guide to reliability of firm and product." A subsequent editorial announced that advertisements would be edited as if they were scientific articles or news items, to "guard against extravagant statements."[3]

In spite of these assurances, and in the absence of an announcement of a modification of these standards, the *Journal* published its first cigarette advertisement in 1933. For more than 20 years it was to accept more than 600 pages of cigarette advertisements from the six major tobacco companies. Although it is difficult to understand how the *Journal* permitted cigarette advertising, there is no mystery whatsoever as to why tobacco companies sought out medical journals: in the words of an Irish proverb, "Truth may be good, but juxtaposition is better." The tobacco companies were buying complacency.

Full-Bodied

The first tobacco company to purchase advertising space in the *Journal* was Liggett & Myers. From October 1, 1933, to July 1, 1938, an advertisement for Chesterfield cigarettes appeared in alternating issues, usually on the premium-space back cover. Although some advertisements suggested Chesterfields were healthful ("Just as pure as the water you drink ... and practically untouched by human hands"—Dec 1, 1933), most were composed of a romantic young couple, a double-entendre catchphrase ("They satisfy!"), and the distinctive Chesterfield logo. The following dialogue was printed below a scene of two lovers snuggled in a one-horse sleigh (Aug 1, 1934):

Woman: "I thank you—I thank you ever so much—but I couldn't even think about smoking a cigarette."

Man: "Well, I understand but they are so mild and taste so good that I thought you might not mind trying one while we are riding along out there."

Perhaps because Lucky Strikes were America's top-selling and most widely advertised brand by the 1930s, the American Tobacco Company may not have wanted to court additional undue medical skepticism concerning its various health-oriented slogans, including, "No throat irritation. No cough." Only one advertisement for Lucky Strike appears to have been published in the *Journal*. Headlined, "A Quarter Century of Research Relating to a Light Smoke," the advertisement discussed American's long-standing effort to solve "an extraordinarily complex problem":

The objective may be stated as: *the perfection of a cigarette with a minimum of respiratory and systemic irritants, and with a fully preserved character, i.e., a perfected acid-alkaline balance — a cigarette in which rich, full-bodied tobaccos have been successfully utilized to produce "A Light Smoke."*

By means of a graph purportedly illustrating the

*Medical Society of the the State of New York

ratio of total volatile acids to total volatile bases, the company claimed that, unlike Brands B, C, and D, Lucky Strike had struck the proper balance between "acidity and basicity." Why the advertising for this brand was discontinued is unclear, for there is no published correspondence or editorial content discussing the advertisement.

Clinical Proof

Philip Morris English Blend cigarettes made their *Journal* debut in 1935, in single-column advertisements drawn to resemble a cigarette. Citing studies published in medical journals, these advertisements were the first to aim squarely at physicians. The basic claim was that Philip Morris, made with the hygroscopic (moistening) agent diethylene glycol, were less irritating than cigarettes made with glycerine or with no such chemical additive. The Philip Morris claim was largely based on an article published in the *New York State Journal of Medicine*. [4]

In the advertisements, reprints of this study and others in *The Laryngoscope* were offered, along with two free packs of Philip Morris. The study reported a variation of an objective technique for the measurement of irritation—the production of edema in the conjunctival sac of rabbits' eyes. In the authors' experiment, edema produced by the instillation of a smoke solution from Philip Morris cigarettes lasted an average of 8 minutes, while the smoke solution from "cigarettes made by the Ordinary Method" caused edema for an average duration of 45 minutes. The advertisements would note that an article in *Laryngoscope* (1935; XLV, No. 2, 149-154) reported "clinical confirmation. When *smokers* changed to Philip Morris, every case of irritation of the nose and throat due to smoking cleared completely or definitely improved" (eg, Dec 1, 1940).

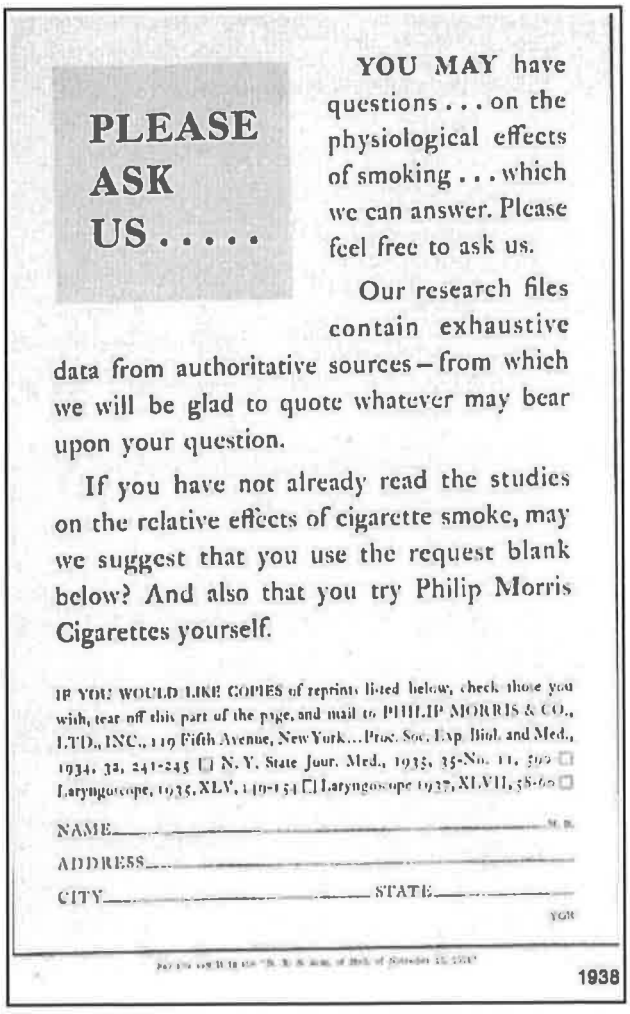
For 15 years, Philip Morris continued to cite such "proof' for the health benefits of these cigarettes, notwithstanding the fact that the authors of the paper in the *Journal* had concluded that cigarette smoking, regardless of the brand, was the cause of irritation to begin with:

For any one patient we may assume that cigarette smoke may play some part in the pathology of the throat condition for which he has consulted his physician.

In addition, in a subsequent article in the *Journal* criticizing the rabbit eye test as a means of evaluating irritation, Sharlit[5] had written

> *... the olfactory nerve ends in the mucous membrane of the nose are far more efficient than the eye for detecting irritating smoke. Indeed, that is precisely part of the job of these nerve ends. When cigarettes made with diethylene glycol (ie, Philip Morris) were so tested by the writer and several others (smoke quickly drawn up through the nose), they were found, unfortunately, to be quite as irritating as other cigarettes.*

Doubtless as the result of this article, Philip Morris issued a retraction of sorts which was published in the issue of Jan 15, 1943:



PLEASE ASK US . . . . .

YOU MAY have questions . . . on the physiological effects of smoking . . . which we can answer. Please feel free to ask us.

Our research files contain exhaustive data from authoritative sources – from which we will be glad to quote whatever may bear upon your question.

If you have not already read the studies on the relative effects of cigarette smoke, may we suggest that you use the request blank below? And also that you try Philip Morris Cigarettes yourself.

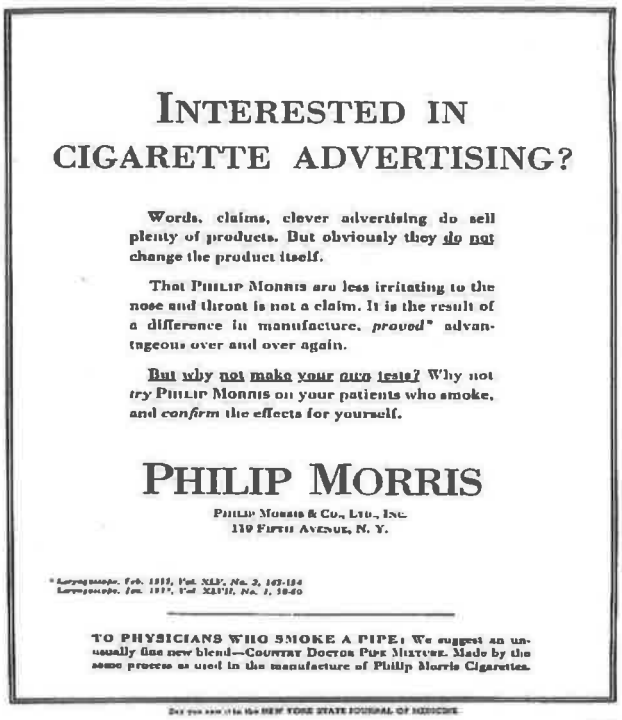
IF YOU WOULD LIKE COPIES of reprints listed below, check those you wish, tear off this part of the page, and mail to PHILIP MORRIS & CO., LTD., INC., 119 Fifth Avenue, New York... Proc. Soc. Exp. Biol. and Med., 1934, 32, 241-245 ☐ N. Y. State Jour. Med., 1935, 35-No. 11, 592 ☐ Laryngoscope, 1935, XLV, 149-154 ☐ Laryngoscope 1937, XLVII, 58-62 ☐

NAME_____

ADDRESS_____

CITY_____ STATE_____

1938



INTERESTED IN CIGARETTE ADVERTISING?

Words, claims, clever advertising do sell plenty of products. But obviously they do not change the product itself.

That PHILIP MORRIS are less irritating to the nose and throat is not a claim. It is the result of a difference in manufacture, *proved** advantageous over and over again.

But why not make your own tests? Why not *try* PHILIP MORRIS on your patients who smoke, and *confirm* the effects for yourself.

PHILIP MORRIS

PHILIP MORRIS & CO., LTD., INC.
119 FIFTH AVENUE, N. Y.

* Laryngoscope, Feb. 1941, Vol. XLV, No. 2, 107-124
Laryngoscope, Jan. 1937, Vol. XLVII, No. 1, 38-40

TO PHYSICIANS WHO SMOKE A PIPE: We suggest an unusually fine new blend—COUNTRY DOCTOR PIPE MIXTURE. Made by the same process as used in the manufacture of Philip Morris Cigarettes.

1942

A DISCLAIMER:

Philip Morris & Company do not claim that Philip Morris cigarettes cure irritation. But they do say that an ingredient—glycerine—a source of irritation in other cigarettes, is not used in the manufacture of Philip Morris.

This did not stop Philip Morris from developing advertising themes throughout the 1940s such as "Why many leading nose and throat specialists suggest... change to Philip Morris" (1948-1949) or from boasting about the integrity of its advertising:

INTERESTED IN CIGARETTE ADVERTISING?

Claims, words, clever advertising slogans do sell plenty of products. But obviously they do not change the product itself. Thai Philip Morris are less irritating to the nose and throat is not merely a claim. It is the result of a manufacturing difference, proved advantageous over and over again (Nov 1, 1945).

Although little Johnny the bellhop appeared each evening on such popular radio programs as "The Edgar Bergen and Charlie McCarthy Show," his smiling face never appeared in the *Journal*. Nonetheless, Johnny was enlisted in printed advertisements in the mass media to promote the theme of Philip Morris' "definitely less irritating" properties. Among the slogans he was shown calling out were, "Don't let inhaling worry you (if you switch to Philip Morris)!" and "An ounce of prevention is worth a pound of cure." Philip Morris never explained why Johnny's growth was stunted.

Slow burn

R.J. Reynolds first advertised in the *Journal* in 1941. Advertisements for Camels appeared in every issue for the rest of the decade, and in every other issue from 1950 to 1953. The early advertisements claimed that Camels, "the slower burning cigarette," produced less nicotine in the smoke. Photographs of men in white laboratory coats peering into test tubes lent a scientific touch. Like Philip Morris, R.J. Reynolds suggested switching brands as the alternative to quitting smoking. Rather than emphasize the irritation issue, R.J. Reynolds chose to play on the use of cigarettes to relieve "the strain

1945

of current life," as illustrated in this advertisement from Nov 1, 1942:

> *In these unsettled times, individuals may tend to display baffling, sub-clinical symptoms. The relationship of these symptoms to smoking and nicotine absorption can be an interesting subject for exploration.*
>
> *However, the success of the physician's program is dependent upon the patient's full cooperation.*
>
> *Your recommendation of Camel cigarettes can be an aid in this direction ...*
>
> *Given adequate support by patients, the physician may find case histories more reliable. In addition, the segregation of such data may facilitate valuable group analyses.*

1952

Although American Tobacco was first to exploit a patriotic wartime theme ("Lucky Strike Green has gone to war"), R.J. Reynolds quickly followed suit by portraying Camels "as the favorite of the armed forces" (Feb 1, 1943) and appealing to physicians to send a carton to their "friends with the fighting forces." Military physicians became "heroes in white" (Mar 1, 1945), whose only rare comfort was a trusty Camel.

Following a series of postwar advertisements praising America's fighting, smoking physicians, R.J. Reynolds introduced a campaign, based on a survey of 113,597 physicians, that claimed, "More Doctors smoke Camels than any other cigarette." The first advertisement in the series (Jan 1, 1946) included a reprint of a "Dear Doctor" letter from the Camel Medical Relations Division, One Pershing Square, New York, NY, which praised its own survey. The "More Doctors smoke Camels" theme could be heard on most prime-time radio programs, including such children's favorites as "Abbott and Costello." Advertisements nearly identical to those that appeared in medical journals also ran each week in the three most popular magazines of the era, *LIFE*, *TIME*, and *The Saturday Evening Post*, thus assuring maximum media saturation.

But R.J. Reynolds managed to top this effort in its direct-to-physician advertising with a campaign for Camels cigarettes that posthumously honored great medical discoverers: Thomas Addison, John William Ballantyne, Sir Charles Bell, John Hughes Bennett, Claude Bernard, Richard Bright, Charles Edoard Brown-Séquard, Paul Ehrlich, Carlos Finlay, Camillo Golgi, William Whithey Gull, Marshall Hall, Herman von Helmholtz, F.G. Jacob Henle, Robert Koch, Joseph Lister, Theobold Smith, William Stokes, Rudolph Virchow, and William Henry Welch. Advertisements in nearly every issue of the *Journal* in 1947 and 1948 praised the perseverance of these men, beneath the headlined slogan, "Experience is the Best Teacher." The advertisements concluded with the line, "Experience is the best teacher in cigarettes too!" and cited statistical proof that Camels were the "choice of experience."

Housecalls

Another way tobacco companies played up to physicians was to provide them with free cartons of cigarettes. This was done either by mail (as part of market research surveys) or by an attractive "detail woman" (who would see to it that a plentiful supply of cigarettes was available in the patients' waiting area) or by exhibits at medical meetings. In 1940 Philip Morris took out space in the *Journal* for an "invitation" to physicians to drop by the cigarette company's booth at the annual convention of the Medical Society of the State of New York. Beginning in 1942, R.J. Reynolds invited physicians to visit the Camel cigarette exhibit at the convention of the American Medical Association (AMA). This advertisement was not unlike a circus poster:

> *See for the first lime the dramatic visualization of nicotine absorption from cigarette smoke in the human respiratory tract.*
>
> *See the giant photo-murals of Camel laboratory research experiments....*

In 1949 Reynolds concocted the "30-day test," whereby unnamed but "noted throat specialists" were used to back up the claim, "Not one case of throat irritation due to smoking Camels!" Philip Morris countered with the "nose test," which it urged physicians to try (Mar 1, 1950). In before-and-after pictures, a young woman was shown exhaling smoke through her nostrils—smiling in the photograph labeled "Philip Morris" and grimacing with her "present brand." The advertisement claimed the doctor-smoker would also "see at once Philip Morris are less irritating."

By 1950, Philip Morris had found a new lure: "Make our doctors' lounge your club," invited one advertisement (June 1, 1950). Brown & Williamson Tobacco Company, trying to attract frightened consumers to filter cigarettes, also worked the medical market. One of its advertisements thanked "the 64,985 doctors who visited Viceroy exhibits at medical conventions" (June 1, 1954).

Out with the bad air ...

Even though the cigarette companies have never publicly acknowledged any lasting harm attributed to their product, they have always attempted to por-

tray various brands as safer and healthier than others. No aspect is more central to the hoax of safer smoking than is the filter. The first advertisement carried by the *Journal* for a filter cigarette was for Viceroy (July 15, 1939): "AT LAST ... a cigarette that filters each puff clean!" ("No more tobacco in mouth or teeth... A note on your office stationery will bring two packages with our compliments.")

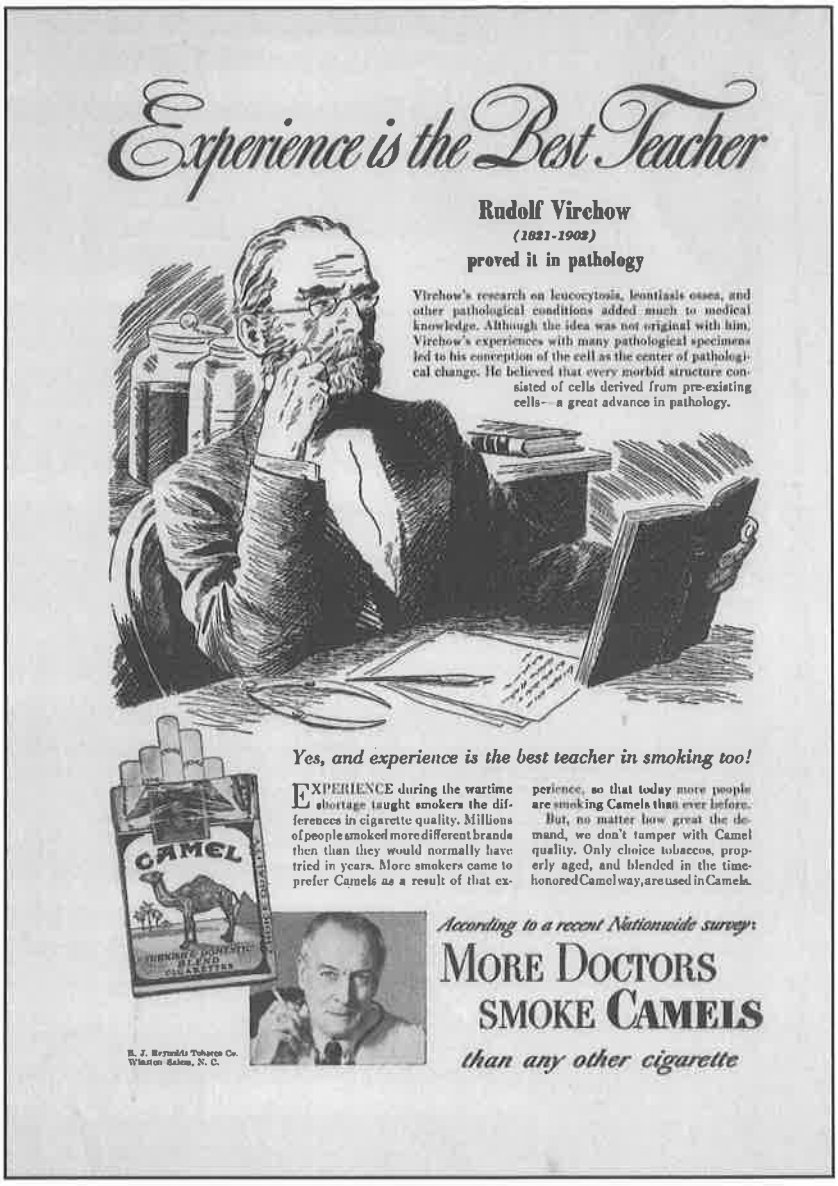
By 1953, following publication of several major studies that left little doubt about cigarette smoking's role as the primary factor in the growing epidemic of lung cancer among men, nearly all the remaining cigarette advertisements in the *Journal* and other medical publications were for filter cigarettes. The drop-off in cigarette advertising in the *Journal* did not merely come about because the companies' ability to deceive or confuse physicians had run its course. Rather, television had become the predominant medium, and the bulk of advertising budgets was shifted into the sponsorship of the most popular programs.

Philip Morris ran its last advertisement in the *Journal* on August 1, 1953; Reynolds exited at the end of 1953, but not before touting a new slogan, "Progress through research." Meanwhile, Lorillard had launched nationally televised "scientific" demonstrations to show the efficacy and implicit medical benefits of its Micronite filter. This campaign was backed up by a heavy dose of advertising in medical publications.

Although the advertisements never disclosed the composition of "Micronite," there is evidence that the material that Lorillard touted as "so safe, so effective it has been sleeted to help filter the air in hospital operating rooms" (May 15, 1954) and "to purify the air in atomic energy plants of microscopic impurities" (Feb 15, 1954) was asbestos. A case report from the Thoracic Services of Boston University Medical School, "Asbestos following brief exposure in cigarette filter manufacture," described a 47-year old man who had been exposed to asbestos dust for a period of nine months in 1953 while working in a factory that manufactured filters containing asbestos.[6] The patient made cigarette filters that consisted of a mixture of Cape Blue asbestos and acetate. According to the second author and a second source[7], the filters were made for Lorillard, although it is possible that these particular filters were in some way different from the Kent Micronite filters.

Brown & Williamson again drew *Journal* readers' attention to the alleged lower tar and nicotine content of Viceroy, "as proved by telling methods acceptable to the United States Government." (Nov 15, 1953). The last cigarette advertisement appeared in the *New York State Journal of Medicine* on January 15, 1955, paid for by Lorillard to proclaim, "Old Gold — the first famous name brand lo give you a filter." This from a company that had advertised Old Gold with the slogan "not a cough in a carload" in the 1930s and 1940s and had ridiculed the early medical reports pointing to the lethal side-effects of smoking with the slogan (also appearing in medical journals), "For a treat instead of a treatment."

Little if any criticism of the policy of accepting cigarette advertising appears to have been published in the *Journal* during the 20 years these advertisements ran. The same is true of *JAMA*, which



published cigarette advertising between 1933 and 1953. But in 1954 a campaign for Kent, which implied an endorsement by the medical profession (merely because the manufacturer had also taken out advertisements in medical journals), incurred the wrath of an editorialist at *JAMA*, who denounced the advertising as "an outrageous example of commercial exploitation of the American medical profession and a reprehensible instance of hucksterism"[8] In a subsequent letter to *JAMA* Irving S. Wright, MD,[9] added that not only were the Kent advertisements misleading (which implied Kents were the choice for persons with vascular disease) but also especially dangerous. Wright described a patient with quiescent thromboangitiis obliterans who suffered a recurrence after having read a Kent advertisement that led him to resume smoking.

Thirty 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 medical magazine, *Physician East*, which lists six physicians on its masthead and is published in Boston, has been running cigarette advertising in 1983. Others, including *JAMA*, carry advertising for CNA Insurance Company, a division of Loews.

Comment

Many goods and services offered in the *Journal* in the past half-century have stood the test of time, but a policy of accepting advertisements for cigarettes is a sad saga for this and all other medical publications that have carried them—and for the entire advertising and publishing fields. It may be too late to publish corrective advertising for promotions that ceased 30 years ago, but even in retrospect the credibility of the publication is harmed. The knowledge and common sense about cigarette smoking *were* there—but so were the mass media to undermine knowledge and cultivate mass denial. One clear lesson is that physicians are not immune to propaganda. But the point of this article (and this entire issue) is that the situation in regard to the promotion of smoking is even more pernicious today. The old advertisements in the *Journal* may seem ridiculous in their images and claims, and we can rationalize that we no longer acquiesce in the

sale of cigarettes in a medical context. But do we? Whenever we flip past the cigarette ad on the sports page of *The Times* or ignore the one on the billboard downtown or on the bus, subway, or taxi that drops the patient off at our offices, we as leaders in society are doing precisely what the cigarette advertisers want us to do: *not* become angry, but rather to become resigned or complacent. Advertising for a product is not solely designed to sell to potential or current users, but also to assure the complacency or tolerance of non-users.

A common attitude among physicians today is that smoking will gradually die out in the next few years and that the cigarette companies will leave cigarettes to diversify into other kinds of businesses. Unfortunately, this is not on the agenda for a single cigarette company, least of all those which are aiming at developing nations.

It is too simple—and naive—a matter to call for a total ban on cigarette advertising, as so many other medical editorialists have done. Even granting an unforeseen awakening by Congress and local governments to the need for such an action, to judge from the events in countries where there have been such prohibitions, the tobacco industry is adept at incorporating its brand names, images, and packaging colors into other media. At LaGuardia and Kennedy international airports, for instance, the red rectangular symbol with the white triangular cut into it does not require a printed message for it to be instantaneously recognized that Marlboro cigarettes are being advertised. The clear solution is to remove all economic incentives for the cigarette companies and their subsidiaries, and the first step may well be a physician-led selective economic boycott. At the rate these conglomerates are growing, if the medical profession misses out on this opportunity, it may one day find itself working for health maintenance organizations operated by Loews, hospitals run by Philip Morris, trauma centers controlled by R.J. Reynolds, outpatient clinics established by Brown & Williamson, professional provider organizations set up by American Brands, and pharmaceutical manufacturers owned by Liggett. To judge from the increasing number of medical research councils, institutes, and science symposia underwritten by tobacco companies, and the medical schools and business schools accepting endowment money from them, this possibility may not be that far-fetched.

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