Doctors and Tobacco

Medicine's Big Challenge

Tobacco Control Resource Centre

The Tobacco Control Resource Centre was established at the British Medical Association (BMA) in London on behalf of the European Forum of Medical Associations and the World Health Organization (WHO). The centre is funded by the European Commission and the BMA, and receives support from other national medical associations.

The work of the Tobacco Control Resource Centre is overseen by the Tobacco Control Advisory Group, which includes representatives from five national medical associations reflecting the demography of the European region.

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Dr Göran Boëthius (Observer)	European Network of Smoking Prevention

Author

David Simpson

Editors

Gillian Shine
Anne Waddingham

Tobacco Control Resource Centre

Bill O'Neill	Director
Sinéad Jones	Project Leader
Lucien Rivière	Information Officer

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Foreword

When, in 1951, Professor Austin Bradford Hill and I were casting around for ways to investigate the relationship between smoking and lung cancer that would confirm (or refute) the conclusions we had drawn from a study of the smoking habits of patients with and without the disease, Bradford Hill came up with a good idea. Let us, he suggested, ask doctors to tell us how much they smoke and then follow them for several years to see who dies first and whether their mortality from lung cancer varies in the way predicted from our earlier studies.

According to Wynne Griffith (personal communication) the idea that doctors would make a suitable group to study came to Bradford Hill one Sunday morning when playing golf and, Wynne Griffith added, "I don't know what kind of a golfer he (is) but that was a stroke of genius." It was indeed, for when we wrote to all the doctors on the British Medical Register in October 1951, over 40 000 (two thirds) gave details of their smoking habits and they have proved so easy to trace that nearly all the men who were not known to have died could be traced 40 years later. The story is, however, apocryphal; for Sir Austin told me that the idea came to him, in the classical manner, in his bath.

The evidence from the study of doctors mounted quickly and the fact that the observations had been made on themselves and their colleagues was, I suspect, a major reason why British doctors, as a group, became so quickly convinced of the reality of the causal relationship and acted on it by giving up smoking. For human nature is such, even among the scientifically trained, that conclusions reached by people we know in our own country and derived from observations on our own compatriots are easier to accept than those reached in distant countries on aliens, particularly if the conclusions require us to modify our own style of life – or so it has seemed in relation to smoking, for the habit (or, in many people, the addiction) was so commonplace and had been accepted as relatively harmless for so long, that it has been difficult to believe that it was the single most important cause of premature death, without some personal experience of the facts.

The situation has, of course, changed in recent years. Valuable evidence has been obtained in many developed countries and there can be few doctors in such countries who are not, in general terms, aware of the hazards of smoking, though not all of them may have fully appreciated the size of the hazards. For when the epidemic is mature and cigarette smoking (as opposed to cigar or pipe smoking or chewing tobacco or taking it as snuff) has been taken up in youth by men who are now in their 70s and 80s, it is found to have killed a quarter of regular smokers in middle age (now definable as from 35 to 69 years) and another quarter later on. And something very similar also applies to women when they have been smoking in the same way for equally long.

The situation may, however, be different, in many developing countries, where smoking is already prevalent but has become common only in the last two or three decades, for doctors in those countries will not yet be seeing the harvest of deaths that prolonged smoking brings, and the media and the general public will be unimpressed, not having seen the effects themselves. Moreover, when they do see them, it cannot be expected that the pattern of deaths will necessarily duplicate the pattern seen in Europe and North America. For tobacco smoke acts synergistically with many other noxious agents, so that the pattern of smoking-related diseases will vary greatly between different cultures,. The emphasis on the harmful effects of smoking on myocardial infarction makes little sense in China and Japan where the disease is relatively rare; it needs to be laid instead on stroke and, in China, also on tuberculosis.

There are, therefore, strong grounds for conducting cohort studies like those of British doctors and of supporters of the American Cancer Society who similarly provided details of their smoking habits, not only for the sake of providing nationally relevant data, but also for what we may be able to learn from the way smoking interacts with different lifestyles. Although the conduct of such studies is an important contribution that a few doctors can make in each of many different countries, the greater contribution that all doctors can make is in the ways outlined in this book, through direct contact with their patients to improve their long term health and through their professional organisations to achieve the same objectives by affecting government policy.

It may be possible, with widespread action, to reduce the prevalence of smoking quite quickly, as has already happened in several countries over the past few decades, but it will take many years of concentrated efforts to reduce it until it is of only minor concern to public health (for I do not expect to see it eliminated while we are so socially inept at eliminating the use of other habituating drugs). The effort required is, however, one to which many doctors are unaccustomed. Patients turn to doctors for absolution not exhortation, and few have been trained in the art of prevention as effectively as in the art of cure. Both require art as well as scientific knowledge to achieve their aim and, in relation to the prevention of smoking, there is no better teacher than David Simpson, who communicates in *Doctors and tobacco* both the science and the art of preventing tobacco-related disease.

Sir Richard Doll
July 1999

Contents

1 Introduction

This book is about doctors and tobacco. It has been written for these reasons:

- For most doctors, tobacco will be the largest preventable cause of disease that they will encounter in their professional lives
- Doctors have such a vital role to play in combating this massive health problem.

The book has two main roles:

- As a manual for national medical associations (NMAs), to enable them to play a leading role in the conquest of the most challenging public health problem
- As a checklist of the types of action available to individual doctors.

In the second role, although the book has been written primarily for doctors in clinical practice who work directly with patients, it is hoped that it will also prove useful to a wider audience, including public health doctors and doctors in other non-clinical specialties. It will also be a useful guide for nurses, paramedical staff, health educators and many others who work in the health services.

It starts by summarising the tobacco problem, and then goes on to outline the ways doctors can help to tackle it, individually and through NMAs.

The publication comes at an important time of change in Europe. It is a time of unprecedented optimism, following the approval of a directive on tobacco advertising in July 1998 by the Council of Ministers of the European Union. This requires all EU member states to enact legislation within a given time frame, to ban most forms of tobacco promotion.

Why should doctors get involved in tobacco control?

- A lot of a doctor's time can be taken up dealing with patients who are suffering from smoking-induced disease
- Doctors are faced every day with a large amount of misery and suffering caused by smoking, more than from any other preventable cause
- Getting involved in tobacco control, as an individual doctor or as part of the NMA's activities, offers an unparalleled opportunity to address *the* big public health issue of our time
- Doctors are regarded as the most reliable source of advice and information on health issues, and are exemplars to the rest of the community.

The importance of this development extends far beyond the countries which are presently members of the EU, as the measures will also have to be adopted by countries seeking to join the EU. In addition, they will become an important standard for other countries in Europe, and indeed those in other parts of the world with links to the EU through development aid, trade, and inter-governmental cooperation.

Another reason for optimism is the significant change within the World Health Organization (WHO). The new director general, Dr Gro Harlem Brundtland, has made tobacco control one of her top priorities, and assembled a dynamic team to run WHO's new programme on tobacco, the Tobacco Free Initiative (TFI).

Sir Walter Raleigh's servant throws a bucket of water over his master thinking he is on fire. By kind permission of the Wellcome Institute.

Over the years, the WHO *Smoke-free Europe* series has provided detailed guidance in all major aspects of tobacco control, and reference can usefully be made to these publications, which are listed in Appendix 3.

Tobacco control is developing faster now than at any time that the concept has existed, and any organisation or individual embarking on a more active role in it will need a guide.

Help is available

Fortunately, the past few years have seen the emergence and growth of international initiatives to provide communications, technical advice and assistance, and to encourage inter-sectoral cooperation for a united, well informed campaign against the common enemy of public health–that is, tobacco.

Increasingly, such help is available via the internet, and NMAs will find it invaluable to have ready access to this information gateway. It will be especially important to become members of GLOBALink, the communications and online information system for tobacco control advocates operated by the International Union Against Cancer (Union Internationale Contre le Cancer, UICC).

Apart from regular information bulletins on European developments, GLOBALink features a number of electronic conferences, and a system whereby a member (such as a medical association in a country where a special tobacco control situation exists) can address all other members with a request for help.

As this publication is aimed primarily at doctors and their NMAs, it is equally important to note the existence of the Tobacco Control Resource Centre (TCRC), located at the British Medical Association in London, United Kingdom.

Another helpful resource is the specialist journal *Tobacco Control*, published by the BMJ Publishing Group. This quarterly publication, covers the full spectrum of tobacco control issues, including original, peer-reviewed papers. For more details, see Appendix 3.

The TCRC was established on behalf of the European Forum of Medical Associations and WHO. It provides a wide range of support and advice to NMAs on tobacco issues, acting as a clearinghouse for information enquiries. It has developed an extensive database to back this work, and has a rapidly developing internet web site (including this book–see details on page 57). The TCRC is funded by the European Commission (EC), WHO and the BMA, and receives support from other NMAs.

In addition, there are other agencies which can benefit NMAs, individual doctors, and other health workers who become involved in tobacco control, especially in those countries of Europe where less action has been taken. Details of these agencies and the services they can provide are listed in Appendix 3.

2 The risks from tobacco

This chapter outlines the main scientific evidence of tobacco as a cause of disease. Because the literature is so vast, only a brief summary can be given here. Those requiring more detail should consult some of the sources cited as references, as well as the many other reviews of the literature which are published periodically. Individual doctors, especially those who take part in media interviews and other public speaking events, will want to develop their knowledge of the problem, and their own styles and techniques for trying to convey the severity of the tobacco problem to lay audiences.

In this chapter

- Tobacco is the major health problem in Europe and worldwide. It is the largest preventable cause of premature death in developed countries.
- Tobacco is a unique public health problem for reasons other than scale, which add to the difficulties of prevention
- Tobacco is consumed in a variety of different ways, though smoking manufactured cigarettes is the main problem.

Among the types of disease tobacco causes are:

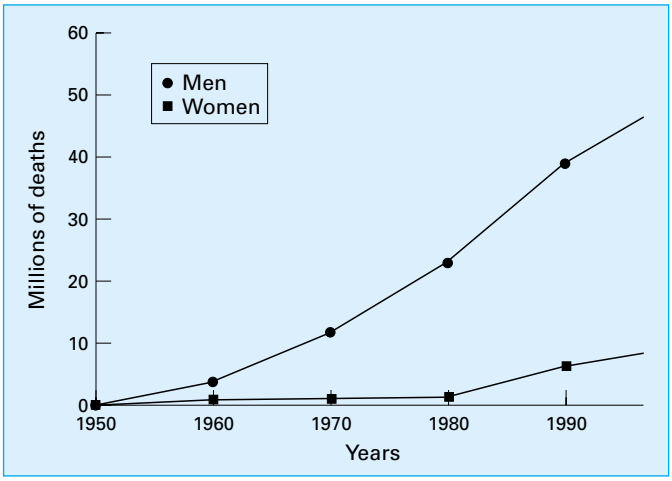
- Cardiovascular disease
- Cancer
- Lung disease other than cancer
- Spontaneous abortion, premature birth, and other reproductive health problems
- Cancer and other diseases from oral tobacco use.

In addition to diseases caused to smokers themselves, cancer, cardiovascular disease, and childhood respiratory diseases can be caused by exposure to other people's tobacco smoke—also known as *passive smoking*, or *environmental tobacco smoke* (ETS). Tobacco consumption also gives rise to a range of costs (and benefits), some of which have a bearing on health policy.

Tobacco: a major health problem

Worldwide, smoking is killing three million people each year and this figure is increasing. In most countries the worst is yet to come, as by the time the young smokers of today reach middle or old age there will be about 10 million deaths per year from tobacco. Approximately 500 million individuals alive today can expect to be killed by tobacco; 250 million of these deaths will occur in middle age.[1]

Tobacco is already the biggest cause of adult death in developed countries, where tobacco now causes a third of all male deaths in middle age (plus a fifth in old age). Although smoking may protect against several fatal and non-fatal conditions, the adverse effect of smoking on health is overwhelmingly negative.[2]



Cumulative number of deaths caused by smoking in industrialised countries, 1950–2000. From data in the WHO Programme on Substance Abuse (1994) and Peto *et al.*[3]

For women in developed countries, the peak of the tobacco epidemic has not yet arrived.

Cigarette smoking can kill in many different ways. In developed countries as a whole, tobacco is responsible for 24% of all male deaths and 7% of all female deaths (although this figure is rising); for men these figures rise to over 40% in some countries of central and eastern Europe. The average loss of life expectancy of smokers is eight years; however, for those who die in middle age (35–69), this is as much as 22 years.[3]

Among British doctors followed for 40 years, overall death rates in middle age were about three times higher among doctors who smoked cigarettes as among doctors who had never smoked regularly.[4] About half of all regular cigarette smokers will eventually be killed by their habit, but it is never too late to stop smoking: among British doctors who stopped smoking, even in middle age, there was a substantial improvement in life expectancy.

Throughout Europe in 1990, tobacco smoking caused three-quarters of a million deaths in middle age (between 35 and 69). In the EU member states in 1990, there were over a quarter of a million deaths in middle age directly caused by tobacco smoking: 219 700 in men and 31 900 in women. Many more deaths were caused by tobacco at older ages (70 and over).[2] In countries of central and eastern Europe, including the former Soviet Union, there were 441 200 deaths in middle age in men and 42 100 deaths in women.

Broadly speaking, the incidence in men of smoking-induced diseases has peaked in a number of the western European countries because of reduced consumption. This reduction is mainly the result of health measures, including health education and increased taxation to discourage consumption.

Smoking-attributable diseases have contributed to the

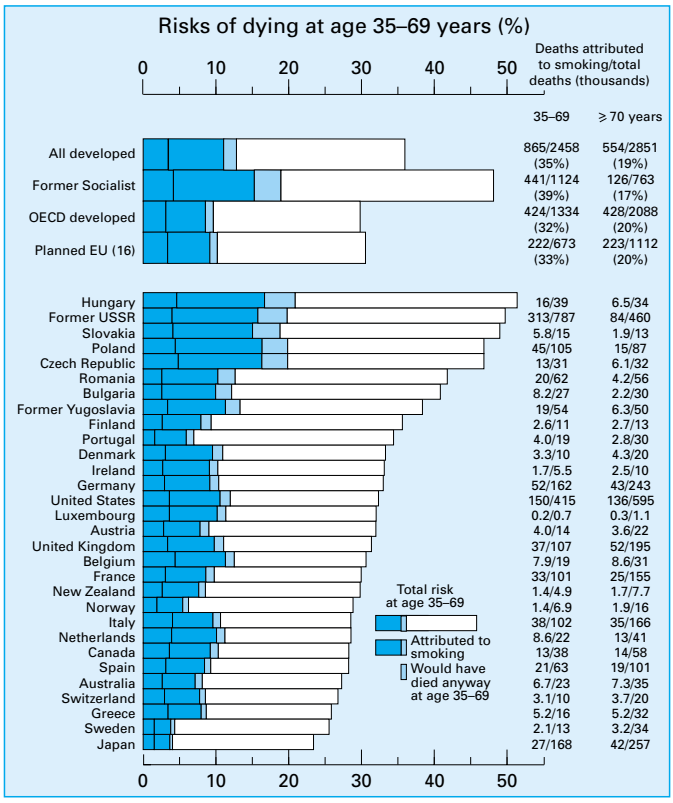
significant increase in mortality in the former socialist countries of central and eastern Europe since 1990, for reasons that are not yet clear.

A useful summary by Peto *et al*, which was part of a major analysis of mortality from smoking in developed countries, shows the risks of dying in middle age (35–69 years) estimated from 1990 mortality rates.[3]

The World Health Organization view

In 1998 the incoming director general, Dr Gro Harlem Brundtland, herself a public health doctor, and former prime minister of Norway, told the World Health Assembly:

"We need to address a major cause of premature death which is dramatically increasing—killing 4 million people this year—and—if we let it go on without action—10 million people in 2030—half of them dying in middle age—not old age. The major focus of the epidemic is now shifting to the developing countries. I refer to tobacco."



Smoking-attributed and other mortality in men aged 35–69 years, estimated from 1990 mortality rates in developed populations. From Peto *et al*.[3]

Why tobacco is a unique public health problem

Tobacco is a unique consumer product: tobacco smoke contains thousands of chemicals, many of them known toxins, and some of them known to damage the blood vessels. It can thus affect every area of the body.

Apart from the amount of disease, disability, and premature death that it causes, tobacco is unique among preventable causes of disease because:

- It is *always* dangerous, rather than being dangerous in excess or when abused, as with other preventable causes of death
- It is highly addictive to many consumers
- It is actively and energetically promoted, often by unscrupulous means, by one of the world's largest and most powerful industries
- Its use harms not only those who consume it, but also other people who are exposed to their smoke.

These important characteristics help to make tobacco a particularly difficult public health problem, requiring urgent action from a wide range of sources, including political action.

How tobacco is consumed

Tobacco use falls into two main categories: *smoking* and *smokeless*. Most tobacco consumed in Europe is smoked, usually in the form of manufactured cigarettes. These may be either be filter-tipped or plain (without a tip). Even in countries where other forms of smoking have been prevalent, the trend, fuelled by the marketing efforts of the powerful transnational tobacco companies, is towards the increasing dominance of manufactured cigarettes. This book, therefore, refers mainly to manufactured cigarette smoking.

In addition, in varying proportions across the European Region, other forms of smoking are practised: hand-rolled cigarettes (popular in Norway, for example), pipe smoking, and cigars (especially in Denmark and the Netherlands).

Smokeless tobacco use falls into two main categories: oral and nasal. By far the most important as a cause of disease is oral tobacco, consumed as snuff (finely ground tobacco leaf, usually with added flavourings), applied in a paper sachet not unlike a small teabag (especially popular in Sweden); or raw, a habit most closely associated with immigrants from South Asia. A small amount of cured tobacco leaf is chewed in parts of Europe, usually by older men. Nasal snuff-taking is now a rare minority habit; evidence of harmfulness is insubstantial and it is not considered a significant public health problem.

The EU has outlawed the introduction and promotion of new oral tobacco products in its member states, following attempts by American manufacturers to market their products in several European countries in the 1980s. However, it is important not to be complacent, and there are signs that oral snuff manufacturers are trying to increase their sales as aggressively as the cigarette companies. Ironically, increased restrictions on smoking in public places may only serve to encourage the sales of this other form of tobacco.

Cardiovascular diseases

Smoking is associated with an increased incidence of *cardiovascular disease* (CVD), including myocardial infarction (MI), stroke, sudden death, and peripheral vascular disease.[5]

In the 40 year follow-up of a prospective study of the mortality of British doctors in relation to their smoking habits, it was found that about half of all smokers had died prematurely from their smoking, about half of those before age 65.[4] Risk increased with consumption, and the causes of

excess deaths included:
- Ischaemic heart disease
- Myocardial degeneration
- Aortic aneurysm
- Arteriosclerosis
- Cerebral thrombosis
- Other cerebrovascular disease.

Smoking appears to accelerate the process of *atherosclerosis*, the common denominator in patients who die from CVD, by leading to serious deleterious effects on the structure and function of blood vessels, platelets, and inflammatory leukocytes.[5]

Smoking is just one of several known risk factors for CVD, and its effects can be clearly seen in countries with low and high levels of other risk factors, and correspondingly low or high CVD rates.[6]

Women show patterns of risk association between smoking and CVD comparable with those of men, albeit with lower total incidence of the diseases.

Atherosclerosis may also narrow the arteries of the legs, causing pain on walking. Over 90% of patients with arterial disease of the legs are cigarette smokers.[7] Continued smoking can cause gangrene and lead to amputation of the toes, feet, or limbs.

In fact, studies in Europe have found that the most important reason for lower limb amputations is *peripheral vascular disease*, for which cigarette smoking is the strongest risk factor.[8 9]

Smoking combined with the use of oral contraceptives increases the risk of a heart attack, stroke, or other cardiovascular disease 10-fold. This effect is more marked in women over 40.[10]

Benefits of giving up smoking

Giving up smoking makes the blood less likely to clot. The heart can pump more blood (and therefore oxygen) around the body with less effort. There is no evidence that smoking low tar cigarettes reduces the risk of heart disease.[11]

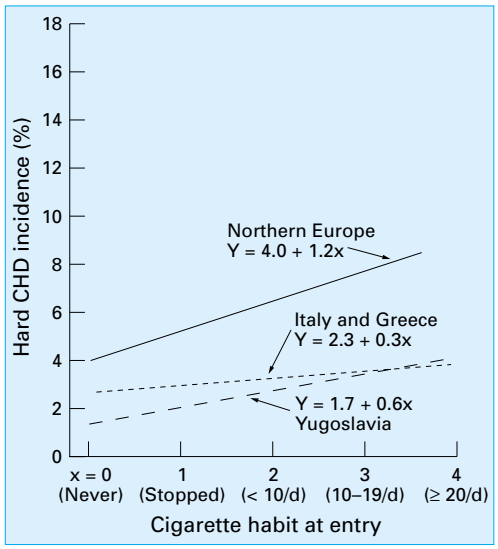
Giving up smoking reduces the risk of a heart attack and is particularly important for those who have other risk factors such as high blood pressure, raised blood cholesterol levels, are overweight, or are diabetic.

Within a year of giving up smoking, the risk is reduced by a half or more, and continues to decline, albeit more slowly, reaching levels of never-smokers after a prolonged period.[12]

Giving up smoking after a coronary attack can halve the chance of a recurrence. Stroke risk decreases significantly in two years and is the same as for non-smokers after five years.[13]

Cancer

Cigarette smoking has been clearly and unambiguously identified[2 14] as a direct cause of:
- Lung cancer
- Cancers of the oral cavity
- Cancer of the oesophagus
- Stomach cancer
- Cancer of the pancreas
- Cancer of the larynx
- Bladder cancer
- Cancer of the kidney
- Leukaemia, especially acute myeloid leukaemia

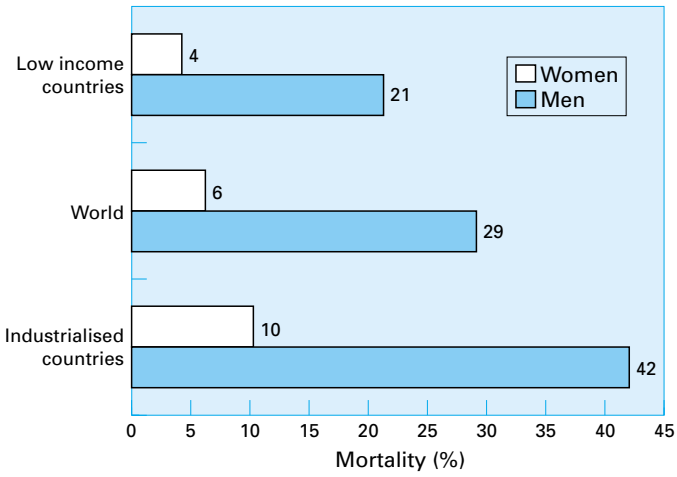


Regression of age-standardised 10-year incidence rate of hard coronary heart disease (CHD) on smoking class of 8717 men free of cardiovascular disease at entry into study in northern Europe, Yugoslavia, Italy, and Greece. Reprinted by permission of the publishers from *Seven Countries* by Ancel Keys,[6] Cambridge, Massachusetts: Harvard University Press, copyright 1997 by the President and Fellows of Harvard College.

Principal diseases caused in part by smoking: mortality rates in cigarette smokers compared with rates in lifelong smokers. From Doll,[14] by kind permission of the publishers.

Cause of death, England and Wales 1993	*(% of deaths)*	*Ratio of mortality rates*		
		British doctors 1951–91	*American population 1984–91*	
		Men	*Men*	*Women*
Cancers of mouth, pharynx, larynx	(0.4)	24.0	11.4	6.9
Cancer of oesophagus	(1.0)	7.5	5.6	9.8
Cancer of lung	(5.6)	14.9	23.9	14.0
Cancer of pancreas	(1.0)	2.2	2.0	2.3
Cancer of bladder	(0.8)	2.3	3.9	1.8
Ischaemic heart disease	(25.3)	1.6	1.9	2.0
Hypertension	(0.5)	1.4	2.4	2.6
Myocardial degeneration	(2.0)	2.0		
Pulmonary heart disease†	(0.3)	∞	2.1	2.1
Other heart disease	(3.0)	—		
Aortic aneurysm	(1.6)	4.1	6.3	8.2
Peripheral vascular disease	(0.1)	—	9.7	5.7
Arteriosclerosis	(0.5)	1.8	2.7	3.0
Cerebral vascular disease	(10.6)	1.5	1.9	2.2
Chronic bronchitis and emphysema	(4.5)	12.7	17.6	16.2
Pulmonary tuberculosis	(0.1)	2.8	—	—
Asthma*	(0.3)	2.2	1.3	1.4
Pneumonia	(9.4)	1.9	2.5	1.7
Other respiratory disease	(1.4)	1.6		
Peptic ulcer	(0.7)	3.0	4.6	4.0
All causes		1.8	2.5	2.1

† No death was reported in non-smoking doctors.
* Smokers include ex-smokers, as asthma may itself cause cessation of smoking.



Estimated percentage of all cancer deaths due to smoking, 1990. From Peto *et al*.[3]

- Cancer of the liver.

The incidence of all these types of cancer is related to the number of cigarettes smoked and years of smoking.

In most countries where habitual cigarette smoking is long established, *lung cancer* is the leading cause of cancer death, and typically around 90% of these deaths are caused by smoking.[15]

In several European countries, lung cancer has overtaken breast cancer as the leading cause of cancer death among women, as women's lung cancer incidence rises following increases in female smoking in recent decades.

Age of starting to smoke is also important: the younger a person starts smoking, the greater their risk of developing lung cancer.

The relative tar yield of cigarettes is less important than the way in which the cigarettes are smoked; lower tar cigarettes may be smoked more intensively or frequently, making them just as harmful as higher tar cigarettes.

Smoking pipes and cigars, like cigarettes, is a risk factor for all cancers associated with the larynx, oral cavity, and oesophagus. The risk for these cancers increases with the number of cigarettes smoked and those who smoke pipes or cigars experience a risk similar to that of cigarette.[16 17]

Risks associated with tobacco and alcohol multiply when exposures occur simultaneously: for those who smoke and drink heavily, their habits are responsible for nine out of 10 cases of *laryngeal cancer* in this category.[18 19] Tobacco and alcohol also act synergistically in the case of *oral and pharyngeal cancers*.[20]

Cigarette smoking has also been found to be associated with *cervical cancer*.[21]

The benefits of quitting: in the absence of pathology, the risk for all cancers will decline after cessation of tobacco use, eventually approaching those of non-users.

Lung disease (other than cancer)

The most important area of lung disease caused by smoking is *chronic obstructive pulmonary disease* (COPD), which includes chronic bronchitis and emphysema.

Cigarette smoking is the most important environmental risk factor for COPD. It causes mucus hypersecretion and progressive airflow limitation.[22–24]

Mortality from COPD is increased substantially with the amount smoked, the risk in smokers of more than 25 cigarettes per day being more than 20 times that of non-smokers.

There is some evidence of a modest reduced risk among smokers of lower tar cigarettes, although this may be countered by more intensive smoking.

Some studies have also shown a synergistic effect in smokers who are also exposed to certain occupational dust or respiratory agents.

Stopping smoking, although not substantially improving ventilatory function, does result in the subsequent rate of decline in forced expiratory volume at 1 s (FEV_1) being slower. It also reduces symptoms of cough, phlegm, wheeze, and breathlessness.

Passive smoking risks

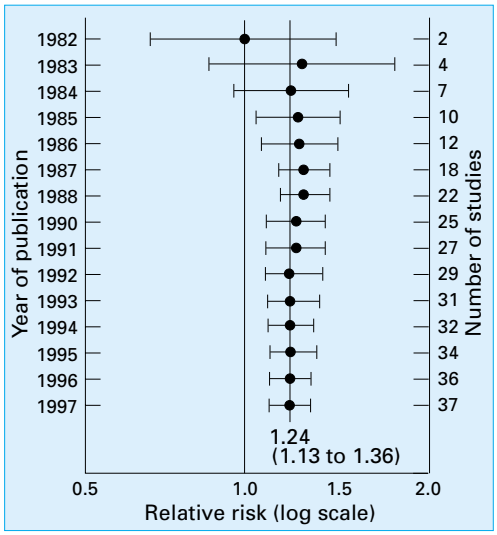
Breathing other people's tobacco smoke, also known as passive smoking or environmental tobacco smoke (ETS) carries serious risks, especially for children and those chronically exposed.[25 26]

Passive smoking is associated with an increase in risk of *chronic respiratory disease* in adults of 25% (10–43%), and increases the risk of acute respiratory illness in children by 50–100%.

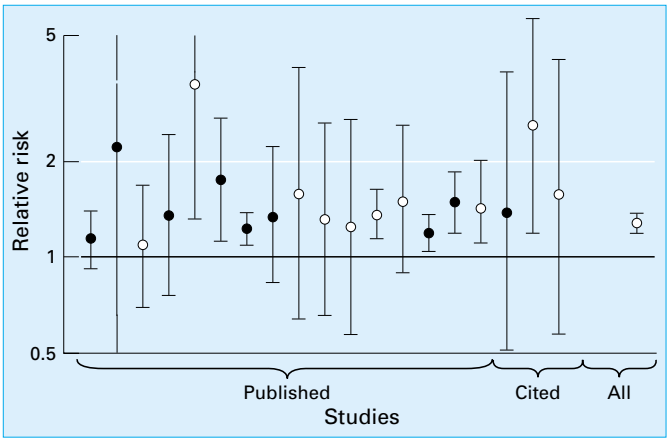
There is strong and consistent evidence that passive smoking increases the risk of *lung cancer*. There is a dose-response relationship between the number of cigarettes smoked and years of exposure and a cohabiting non-smoker's risk of lung cancer.[26]

Breathing other people's smoke is also an important and avoidable cause of *ischaemic heart disease*, increasing an exposed person's risk by approximately 25%. This is mainly explained by a non-linear, dose-response relation between exposure to tobacco smoke and risk of heart disease.[27]

Maternal smoking doubles the risk of *sudden infant death syndrome*. The relationship is almost certainly causal and smoke from the mother and father are important.[28]



Cumulative pooled estimate of relative risk (bars show 95% confidence intervals) of lung cancer from studies of women who were lifelong non-smokers living with a smoker, compared with those living with a non-smoker. (Number of studies on which each pooled estimate is based is shown on the right.) From Hackshaw *et al*,[26] by kind permission of the BMJ Publishing Group.



Relative risk estimates (with 95% confidence intervals) adjusted for age and sex, from nine prospective studies (solid circles) and 10 case-control studies (open circles) comparing ischaemic heart disease in lifelong non-smokers, whose spouse currently smoked, with those whose spouse had never smoked. From Law,[27] by kind permission of the BMJ Publishing Group.

Children whose parents smoke have an increased risk of respiratory problems, and although maternal smoking has a greater effect than paternal smoking, the effect of only the father smoking is significant. Such children also have an increased risk of acute and chronic *middle ear disease*. All these conditions appear to be causally related.[29]

Oral and nasal tobacco

As with smoking, tobacco is also highly dangerous when used in smokeless forms. It causes *cancers of the oral cavity, pharynx, and larynx*.[30–32]

There is evidence of an association between smokeless tobacco and a variety of non-cancerous and pre-cancerous conditions, especially *leucoplakia*.[33 34]

Smokeless tobacco use is implicated in the development of *coronary artery and peripheral vascular disease, hypertension, peptic ulcers*, and *foetal toxicity*.

Smokeless tobacco users can have levels of nicotine in their blood as high or higher than those found in cigarette smokers.

Smoking and reproduction

Smoking increases the risk of *spontaneous abortion*, and there is a higher risk of *premature birth* and *low birthweight* among babies of smoking mothers. Smoking women also tend to reach menopause earlier than non-smokers.[10]

In men, there is increased risk of *impotence* among smokers[35] and men with marginal semen quality may benefit from quitting smoking.[36]

The health care and other costs of tobacco

Although this chapter, so far, has dealt with diseases caused by tobacco, it is also important to note the costs of treating these diseases, and also other economic and financial costs of tobacco.

There are obviously considerable costs in terms of health care (often when resources are already severely stretched); and there are other, related expenses associated with the substantial health problems caused by tobacco. There are also other costs outside the health sector, as well as some benefits.

Summarised below are some main areas of costs and benefits of tobacco. Some are costs to government only (transfer costs), rather than real costs to the country. Some, particularly the benefits, are disputed by economists, because they do not take account of the alternative scenarios.

Costs of tobacco include expenses relating to:

- Extra health care for people suffering from diseases caused by tobacco
- Lost productivity of smokers who die, or who have greater sickness absence from work than non-smokers
- Pensions paid early to the dependents of smokers killed by their habit (transfer cost)
- Fires caused by smoking materials
- Greater cleaning, maintenance, and decoration of buildings and public transport facilities where smoking is permitted, compared with smoke-free areas.

Benefits may be considered to include:

- Employment generated by the manufacture, advertising, distribution, and sale of cigarettes (although a greater level of employment may be generated from alternative consumption)
- Savings in state pensions from smokers not living long enough to claim their pensions or with reduced years of survival
- No health care costs in older age for those smokers who die early
- Tobacco taxes (government benefit).

Costs and policy

In most countries, social and health policy is not made strictly in accordance with relative financial benefits or costs, despite the apparently increasing tendency of governments throughout the European Region to emphasise this criterion.

Some economic studies have demonstrated that a significant and sustained reduction in smoking within a population is followed by savings in health care and other costs in the short-to-medium term.

In the longer term, however, there tends to be a net cost to the economy, because of the greater proportion of people reaching old age, and because old people use the health services more than younger people do, even if they are non-smokers. To base policy on this would be no more acceptable in a civilised society than to abandon efforts to prevent road traffic accidents on the grounds that they provide employment for ambulance crews, doctors, nurses, and vehicle repair mechanics.

The main reasons for raising tobacco tax are:

- To help pay for the government's overall programme of spending
- To discourage consumption
- To pay for the harm it causes.

The wider economic aspects of tobacco are sometimes raised in the context of health policy discussions, not always appropriately. Because of the complexities of the subject, it can be helpful for NMAs and others working on tobacco control to involve a health economist, to help procure the relevant evidence and policy arguments from this specialised area of study.

A discussion of tobacco tax can be found in the section on raising prices through taxation, in Chapter 11.

References

1 Peto R. Smoking and death: the past 40 years and the next 40. *BMJ* 1994;**309**:937–9.
2 Boyle P. Cancer, cigarette smoking and premature death in Europe: a review including the recommendations of European Cancer Experts Consensus Meeting, Helsinki, Finland, October 1996. *Lung Cancer* 1997;**17**:1–60.
3 Peto R, *et al. Mortality from smoking in developed countries 1950–2000*. Oxford, UK: Oxford University Press, 1994:A22.
4 Doll R, *et al*. Mortality in relation to smoking: 40 years' observations on male British doctors. *BMJ* 1994;**309**:901–11.
5 Jeremy JY, *et al*. Cigarette smoking and cardiovascular disease. *J R Soc Health* 1995;**115**:289–95.
6 Keys A. *Seven countries*. Cambridge, Massachusetts: Harvard University Press, 1980.
7 Laing SP, *et al*. The prevalence of cigarette smoking in patients with peripheral arterial disease. In Greenhalgh RM, ed. *Smoking and arterial disease*. London, UK: Pitman, 1981.
8 Rommers GM, *et al*. Epidemiology of lower limb amputees in the north of the Netherlands: aetiology, discharge destination and prosthetic use. *Prosthet Orthot Int* 1997;**21**:92–9.
9 Verhaeghe R. Epidemiologie et prognostic de l'arteriopathie obliterante des membres inferieurs. (Epidemiology and prognosis of peripheral obliterative arteriotherapy.) *Drugs* 1998;**56**(suppl 3):1–10.
10 Chollat-Tracquet C. *Women and tobacco*. Geneva, Switzerland: World Health Organization, 1992:38.
11 Royal College of Physicians of London. *Health or smoking: follow-up report of the Royal College of Physicians of London*. London, UK: Pitman, 1983.
12 US Department of Health and Human Services. *The health benefits of smoking cessation. A report of the Surgeon General, 1990*. Rockville, Maryland: Public Health Service, Centers for Disease Control, Office on Smoking and Health, 1990. (DHHS Publication No (CDC) 90-8416.)
13 Wolf PA, *et al*. Cigarette smoking as a risk factor for stroke. *JAMA* 1988;**259**:1025–9.
14 Doll R. Uncovering the effects of smoking: historical perspective. *Stat Methods Med Res* 1998;**7**:87–117.
15 Boyle P, Maisonneuve P. Lung cancer and tobacco smoking. *Lung Cancer* 1995;**12**:167–81.
16 US Department of Health, Education, and Welfare. *Smoking and health. A report of the Surgeon General, 1979*. Rockville, Maryland: Public Health Service, Office on Smoking and Health, 1979. (DHEW Publication No (PHS) 79-50066.)
17 Bofetta P, *et al*. Cigar and pipe smoking and lung cancer risk: a multicenter study from Europe. *J Natl Cancer Inst* 1999;**91**:697–701.
18 Franceschi S, *et al*. Smoking and drinking in relation to cancers of the oral cavity, pharynx, larynx, and esophagus in northern Italy. *Cancer Res* 1990;**50**:6502–7.
19 Andre K, *et al*. Role of alcohol and tobacco in the aetiology of head and neck cancer: a case-control study in the Doubs region of France. *Eur J Cancer Part B Oral Oncol* 1995;**31**:301–9.
20 Guenel P, *et al*. A study of the interaction of alcohol drinking and tobacco smoking among French cases of laryngeal cancer. *J Epidemiol Commun Health* 1988;**42**:350–4.
21 Doll R. Cancers weakly related to smoking. *Br Med Bull* 1996;**52**:35–49.
22 Pride NB, Burrows B. Development of impaired lung function: natural history and risk factors. In Calverly P, Pride N. *Chronic obstructive pulmonary disease*. London, UK: Chapman & Hall, 1995:69–91.
23 Strachan DP. Epidemiology: a British perspective. In Calverly P, Pride N. *Chronic obstructive pulmonary disease*. London, UK: Chapman & Hall 1995:47–67.
24 Rijcken B, Britton J. Epidemiology of chronic obstructive pulmonary disease. *Eur Respir Mon* 1998;**7**:41–73.
25 Law MR, Hackshaw AK. Environmental tobacco smoke. *Br Med Bull* 1996;**52**:22–34.
26 Hackshaw AK, *et al*. The accumulated evidence of lung cancer and environmental tobacco smoke. *BMJ* 1997;**315**:980–8.
27 Law MR, *et al*. Environmental tobacco smoke exposure and ischaemic heart disease: an evaluation of the evidence. *BMJ* 1997;**315**:973–80.
28 Anderson HR, Cook DG. Passive smoking and sudden infant death syndrome: review of the epidemiological evidence. *Thorax* 1997;**52**:1003–9.
29 Cook DG, Strachan DP. Summary of effects of parental smoking on the respiratory health of children and the implications for research. *Thorax* 1999;**54**:357–66.
30 Pershagen G. Smokeless tobacco. *Br Med Bull* 1996;**52**:50–7.
31 US Department of Health and Human Services. *The health consequences of using smokeless tobacco. A report of the advisory committee to the Surgeon General*. Bethesda, Maryland: Public Health Service, National Institutes of Health, 1986. (NIH Publication No 86-2874.)
32 International Agency for Research on Cancer. *Tobacco habits other than smoking: betel-quid and areca-nut chewing; and some related nitrosamines*. Lyon, France: IARC, 1985.
33 Gupta PC, *et al*. Primary prevention trial of oral cancer in India: a 10-year follow-up study. *J Oral Pathol Med* 1992;**21**:433–9.
34 Grady D, *et al*. Oral lesions found in smokeless tobacco users. *J Am Dent Assoc* 1990;**121**:117–23.
35 Mikhailidis DP, Jeremy JY. Smoking and erectile impotence. *Int Angiol* 1993;**12**:297–8.
36 Vine MF. Smoking and male reproduction: a review. *Int J Androl* 1996;**19**:323–37.

3 Women and young people

This first part of this chapter deals with special considerations concerning tobacco and women, and the second part with children and adolescents. Both groups need special consideration and protection, especially as they are seen as special targets by the tobacco industry.

In this chapter

- Women in most countries have significantly lower smoking rates than men, making them—especially young women and girls—a special target of the tobacco industry. The fact that women's smoking history means that so far, they have a lower incidence of smoking-induced diseases than men, has tended to lead to less attention being given to preventive measures aimed at women. NMAs will want to work with organisations and media that are especially relevant to women, to facilitate activities in this area.
- Children and adolescents are particularly vulnerable to other people's tobacco smoke, a susceptibility which begins even before birth. They are the most important target of all for the tobacco industry, as most smokers start smoking when they are still children, and few non-smoking adults take up the habit.

Women

In most countries in the European Region, women began smoking several decades after men, due to social taboos and a relative lack of personal spending power. The second half of this century, however, has seen a rise in female smoking rates, often to equal, or in some cases even to exceed, those of men. The reasons for this rise, which may offer hints on how to prevent smoking among women and girls, include:

- Changing social and economic status
- Targeting by tobacco companies
- Health education messages not relevant to women
- Lack of health education designed specially for women.

The forgotten women

Early health promotion campaigns about smoking often referred to activities or characteristics which then appeared to be more relevant at the time to men than to women—for example, sporting achievement or physical fitness. This may have been in part due to lack of awareness among health educators, and also the fact that, at the time, women's disease rates from smoking were far lower than men's reflecting a much later start in consumption. It is only in the last two decades that women have been recognised as a group needing special attention.

Special promotions which tobacco companies have used to target women and girls include:

- Special brands, including "Slim" cigarettes
- Advertisements in women's magazines
- Sponsored fashion events
- Sponsorship of popular music, discos, television, films and video, and sports with high female appeal.

The "Slim" cigarette

Market research has shown tobacco companies that many girls and women, especially young women, strive to be slim, or at least identify with the preference for slimness in the world of female fashion; and many women believe smoking helps them to avoid weight gain.

Some women also seem to be attracted by cigarettes that are longer and slimmer than the brands favoured by men, especially if they are distinctively packaged in feminine colours. The cigarette can become a fashion accessory, a personal statement about how a woman smoker would like the world to see her.

For some, the distinctive image of a "women's cigarette" may be an important factor in overcoming the old taboos against women smoking. A brand of "Slim" cigarettes, or "Slims", is a marketing concept that combines all these appeals, and is thoroughly exploited by cigarette companies to recruit and retain female smokers.

Women's magazines tend to carry large amounts of cigarette advertisements, with the honourable exception of some which refuse them on principle.

Women's magazines that accept cigarette advertisements tend to devote significantly less coverage to tobacco in their health pages than those which refuse them; in some cases virtually no mention is made of the problem, while much less serious health issues may be repeatedly covered at length.[1]

Tobacco advertising targeted at women aims to reinforce perceptions that cigarettes are glamorous, fashionable, facilitate social success, help reduce stress, and control body weight, all powerful attractions among young women in many European countries.

Women and tobacco: concern too late

Unfortunately, the full importance of smoking as a vital issue in women's health has only been recognised recently. The medical and health professions, as well as political and social activists, writers, and journalists comprising what has often been called "the women's movement", were slow to understand the importance of women's smoking.

In western Europe, in the early days of the women's movement, the focus on health was largely concentrated on reproductive health issues, any concern about tobacco being dismissed as irrelevant. Some commentators even said that such concern ran counter to the general trend for women to

How the tobacco industry reaches European women

A study of 111 women's magazines in 17 European countries showed how tobacco advertisements in these magazines provided tobacco companies with a direct way of targeting women, and gave the advertisements some credibility because of the image of the magazine. The study found that:

- Only four magazines voluntarily refused such advertising
- Women in many countries saw positive images of smoking in tobacco advertisements
- Magazines that took tobacco advertising were also less likely to have given any major coverage to health issues related to smoking
- Some magazines, however—in Sweden, for example—were taking a comprehensive and constructive approach to smoking and health.[1]

claim the right to determine their own lives, and participate in all activities which had hitherto been largely male.

Women and disease from smoking

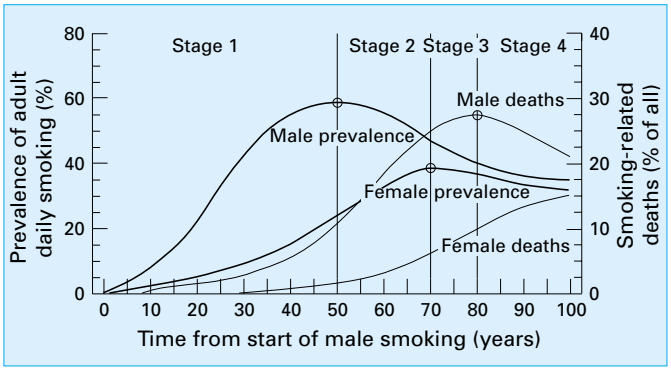
Sadly, smoking is one activity that women would have been well advised to forego, as demonstrated by rapidly increasing female lung cancer rates in many European countries. So drastic has this trend been that in a number of countries where breast cancer had long been the leading cause of death from cancer among women, lung cancer has already overtaken it.

Early perceptions that women were less susceptible than men to disease from smoking have been found to be largely incorrect, with the minor exception of the relative contribution of smoking within the overall spectrum of risk factors for cardiovascular disease in pre-menopausal women. By contrast, in relation to reproductive health, women smokers suffer additional risks of disease compared with men.

"If women smoke like men, they will die like men."

Professor Sir Richard Peto, University of Oxford, United Kingdom.

Morbidity and mortality rates among women who have been lifetime smokers, and with similar consumption levels to men, have proved this all too true.



Standard model for the dissemination pattern of the smoking epidemic. From Ramstrom,[2] by kind permission of Karger, Basel.

What can NMAs do about women and smoking?

Any group set up by the NMA to address the tobacco problem must be aware of the special issues of women's smoking. The group should consider the following:

- Include women members
- Involve those with expertise in this field, or who are motivated to acquire it
- Set up a working group to focus on women and smoking, especially if the issue has received little attention to date
- Review the national situation and identify special target groups that can help
- Educate potential allies about the issue
- Consider organising a special conference on the topic, to kick-start the process of involving a wide range of organisations.

What every doctor can do about women and smoking

The tobacco industry is targeting women, which means that doctors need to do the same, by:

- Giving special attention to pregnant patients who smoke, to help them quit
- Using obvious opportunities, such as when prescribing oral contraceptives, to advise women who smoke to quit
- Encouraging all female patients who smoke to quit
- Supporting the NMA's programme on women and smoking.

Who can help the NMA on women and smoking?

- Publishers and staff of women's publications
- Women's organisations
- Women's sections of professional organisations and labour unions
- Prominent women who have shown leadership on women's health issues.

There is an international network of organisations and individuals concerned about smoking, INWAT (see Appendix 3), which will be able to offer contact with colleagues in other countries who have focused on this issue.

A challenge for leading women NMA members

If women's organisations have not been playing their part in the fight against tobacco, they are obvious targets to recruit to the cause.

Leading women NMA members (and other female health professionals) should try to involve the leaders of women's organisations in meetings and other activities of the tobacco group. They can then learn about the tobacco problem and the special concerns about women's smoking, and begin to play a role in the campaign.

Children and adolescents

Children are clearly the most vulnerable group in terms of their need for protection on two fronts:

- Other people's smoke
- Tobacco promotion, and other influences which may encourage them to start using tobacco.

Everyone agrees: we must stop children from starting to smoke; but …

Most smokers start smoking while they are still children.

Even if their access to cigarettes is limited, a clear pattern emerges:

- Occasional experimentation with smoking
- Experimentation becomes regular
- Regular smoking becomes a daily habit
- The habit becomes a habituation or addiction, as smokers become adults with more disposable income.

"People who choose to smoke…"

The public position of the tobacco industry is that smokers "choose to smoke", and that smoking is "an adult custom" which children should avoid.

Freedom of choice is clearly a powerful concept to invoke, but in this context, is wholly inappropriate and grossly abused by the tobacco industry.

Obviously, children do not exercise free, informed, adult choices with regard to smoking. Internal tobacco industry documents released in American legal trials clearly show how strenuously the companies work to attract children to smoking. Despite the admissions of some of their American leaders, the same companies are busily using the same tricks today throughout Europe.

Children and environmental tobacco smoke

Even before birth, children's health may be affected by parental smoking, particularly that of the mother, and these effects may persist for many years. Exposure to other people's smoke can cause or contribute to cot deaths, serious respiratory illness and other health problems, including early onset of asthma attacks.

Children and tobacco promotion

- Children are specially targeted by tobacco advertisers; this is strenuously denied, but is proved by internal industry papers
- Targeting of children may be very subtle, and the result of careful research–for example, via tobacco-sponsored sports events of which televised relays are known to be watched by large numbers of children.

Children see tobacco promotions constantly, including regular advertising–such as on billboards–sponsorship, and other promotional activities. As a result:

- They hold more positive attitudes about tobacco
- They are encouraged to experiment with smoking.

Other influences on children's smoking are:

- Smoking habits of parents, teachers, elder siblings, members of their peer group and role models
- Attitudes to smoking of parents, teachers, other significant adults and peers.

As they grow up and experiment with smoking, children are not affected for long by knowledge of the diseases they may contract as a result. These tend to seem far too remote from their own experience and imagination–serious disease is associated with people of (to them) great age, with whom they cannot personally identify.

"We must start with the children!"

This is the most frequently heard response of those who come new to the problems of smoking. The sentiment is understandable, but too often it is intended to mean that almost all effort should be concentrated on child-related activities, especially health education through schools. Experience has shown, however, that no single aspect of tobacco control policy alone will solve the tobacco problem.

The stark truth is that more has been achieved so far by encouraging adults to stop smoking than by preventing the uptake of smoking by children.

This does not mean that we should give up trying to deliver good health education programmes to young people, but it is unrealistic to concentrate on it to the exclusion of other activities.

Adolescence: key time for starting

The most critical time for recruitment to smoking is adolescence. In this period, a child moves from a primary school, in which he or she has risen to be in the top year, to a new, "big" school, where the child is suddenly back in the most junior year. Social pressures are great at this time, as children struggle to find their identities and establish themselves among their peer group. Anything that may make them appear outwardly in control, "cool", and adult, will be tempting to the child to experiment with.

NMAs, children, and smoking

The NMA's tobacco group (see pages 30–31) should:

- Review all aspects of the children's smoking
- Recruit or co-opt experts to the group
- Seek to develop a coordination role where none exists.

If there are existing programmes targeted at children, it may not be appropriate or necessary for the NMA to play the leading role. Nevertheless, it is important that the NMA's tobacco group keeps the issue of children and smoking in focus, and ensures that all active parties coordinate their work to maximise the use of their skills, and to avoid duplication of effort.

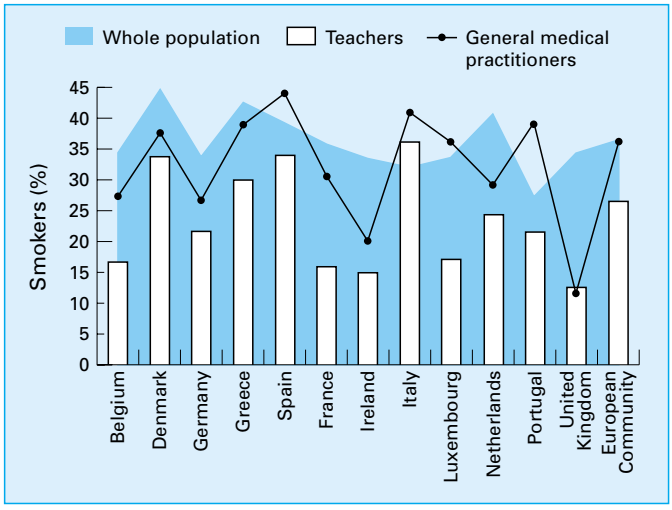
More about children is contained in the section dealing with tobacco control policy, under public education programmes.

References

1 Amos A, *et al.* Women's magazines and tobacco in Europe. *Lancet* 1998;**352**:786–7.

2 Ramstrom LM. In Bollijer CT, Fagerström K, eds. The tobacco epidemic. *Prog Resp Res* 1997;**27**:65.

3 Huber GL, *et al.* In Bollijer CT, Fagerström K, eds. The tobacco epidemic. *Prog Resp Res* 1997;**27**:28, 45.



Consumption of cigarettes by key "role model" figures (teachers and general medical practitioners) in the European Union as a whole and in several western European countries. From Huber *et al*,[3] by kind permission of Karger, Basel.

4 Tobacco and inequalities

This chapter deals with the special considerations concerning tobacco and various minority groups in the population, which need to be addressed when planning and carrying out tobacco control activities.

In this chapter

In most countries, there are marked differences in the way tobacco affects different population groups. As with other public health problems, it is important to consider these differences, to try to target groups which are most at risk, and to maximise what can be achieved with available resources.

Groups which tend to be especially vulnerable include:

- Lower socioeconomic groups
- Ethnic minorities, including immigrants.

The sections which follow examine the ways that people in each of these groups tend to acquire the tobacco habit, and how they may best be protected.

Lower socioeconomic groups

In countries with a long history of smoking and tobacco control, smoking has shown remarkable changes with regard to its relative prevalence among different socioeconomic groups.

Who smokes what: times have changed

Typically, in the early days of cigarette smoking in western Europe at the beginning of this century, it was men in the upper socioeconomic groups who tended to smoke cigarettes, which were handmade and expensive. Those in the lower groups smoked fewer cigarettes, although they smoked tobacco in pipes, or in some cases chewed it.

A similar socioeconomic gradient was found for other habits associated with disease, which now tend to be classified together as lifestyle factors, such as alcohol consumption, lack of physical exercise, and obesity: those with more money exhibited these factors most, whereas those with less money were less likely to have them.

Since then, there has been a reversal in the socioeconomic gradient of cigarette smoking: the professional people have the lowest smoking rates, whereas the unskilled manual workers smoke most. Again, a similar trend has occurred in relation to other lifestyle factors.

Smoking tends to be closely bound up with other lifestyle factors in the disease rates that are found in different socioeconomic groups. Those with least resources, who also tend to be those who have least education, least access to screening and reliable health information and advice, and in other important ways are least likely to change their lifestyles for health reasons, present the greatest challenge for public health.

To promote and communicate ideas, and provide encouragement to people in these groups to make healthy changes in their lifestyles, demands all the skills of imagination and creativity that are commonly used—and highly paid for—to promote the most popular commercial products and services (including those which contribute to the most striking examples of health inequality).

Arguments against the unfettered freedom of communication for tobacco advertisers have a special relevance when considering the welfare of groups who are particularly vulnerable to such advertising, and at whom it is increasingly directed.

In view of the inequalities of smoking-induced disease rates among those at the bottom of the economic pile, protection seems more relevant than the freedom to be exposed, when considering the powerful and highly misleading images promoting the use of the most dangerous consumer product the world has ever known.

NMAs and lower socioeconomic groups

The NMA's tobacco group should:

- Review the issues associated with smoking among lower socioeconomic groups
- Co-opt members or others with special experience—for example, medical advisors to labour unions, or doctors who

By kind permission of the International Union Against Cancer.

work in occupational health, write health columns for the more popular newspapers, or regularly broadcast on health issues on popular radio and television channels
- Constantly review communication efforts to ensure maximum impact on lower socioeconomic groups.

Health economists

The services of a health economist will be especially helpful in this area. This is because one of the objections that will be raised to comprehensive tobacco control policy, by the tobacco industry and by ill-informed politicians, will be based on the assumption that such policy (which will include raising the price of tobacco in real terms, through tax rises) will be socially regressive, hitting the lower income groups worse than the better off.

As will be seen in the section on raising prices through taxation (Chapter 11), this is not strictly true, nor does it take account of the disproportionate future health benefits among lower socioeconomic groups which will result from a tax rise; in fact, this aspect of policy can be seen as socially progressive.

Expert help is needed to obtain and interpret the necessary data for dealing with such arguments, especially in the often politically charged atmosphere surrounding issues affecting the lower paid sections of the population.

Ethnic minorities, including immigrants

Many of the same points as outlined above for lower socioeconomic groups apply to:
- Ethnic minorities
- Temporary or permanent groups of immigrant workers and their families
- Those without permanent place of abode, such as Romanies and other travelling people.

Such groups may have different patterns of tobacco consumption from the general population, and special susceptibility to various tobacco-attributable diseases. Most important, where such groups contain a significant proportion of people who are not literate in the country's main language(s), they may miss much of the information which conveys health messages to the general public.

From a book on doctors and tobacco, *Hekim ve sigara*, published by the Turkish Medical Association.

NMAs and ethnic minorities

The most important role for public health policymakers, including national medical associations, is to take account of such minorities in any tobacco control work. The NMA tobacco group should:
- Co-opt representatives from minorities
- Include doctors or other health workers who care for minorities
- Act as forum bringing ethnic minorities' health leaders together, encouraging them to take action on tobacco
- Ensure that all activities are coordinated within the country's overall programme of tobacco control.

Any initiatives that are aimed at the general public, such as the production of information leaflets about tobacco, should be carried out with participation from minorities' leaders and health specialists, in such a way as to ensure that minority groups are not excluded from the impact of the work.

5 The potential of doctors

This chapter suggests why doctors have probably the greatest potential of any group in society to promote a reduction in tobacco use, and thus, in due course, a reduction in tobacco induced mortality and morbidity.

In this chapter

- Doctors are in a uniquely powerful position to help in the fight against tobacco
- Much of the pioneering research and early political lobbying for tobacco control was undertaken by doctors
- Doctors led the way in realising that they alone cannot solve the tobacco problem, which requires commitment and specialist skills across a wide spectrum of professionals.

Doctors: in a uniquely powerful position

Several interlinked qualities give doctors their special effectiveness:

- Detailed knowledge about disease
- Reputation as independent and caring experts on health
- Positions as advisers on health issues
  - to individuals
  - to public and private organisations
  - to communications media
- Unique opportunities to give advice on a one-to-one basis and in a clinical setting, where patients may be most receptive
- Lines of access to decision makers
- Generally secure and respected position in society.

Early pioneers

A brief history of tobacco control in the United Kingdom provides a striking example of the potential of doctors as a major force in tobacco control, although as will be seen, part of what happened was somewhat fortuitous.

In common with other industrialised societies, the early decades of the 20th century in the United Kingdom saw the rapid adoption of habitual, daily cigarette smoking among men, followed by the emergence of steadily increasing mortality rates from cancer of the lung, previously a very rare disease.

A number of case-control studies were carried out, showing a strong association between the amount smoked and the development of lung cancer. Two scientists, Richard Doll and Austin Bradford Hill, concluded that "smoking is a factor, and an important factor, in the production of carcinoma of the lung". However, this conclusion was not generally accepted, and other scientists suspected that the association was an artefact of the investigation methodology, or that there was confounding between smoking and some other factor.

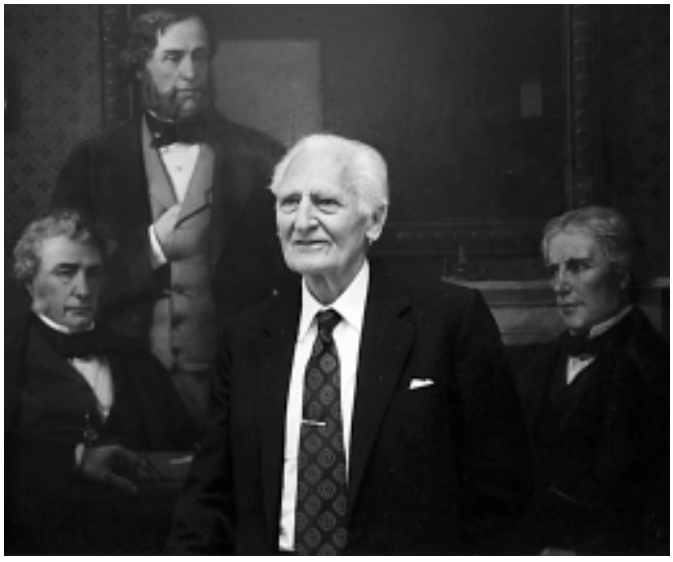
Doll and Hill realised that a different research methodology was needed. Instead of another case-control study of patients suffering from lung cancer, they decided on a prospective study, starting with a group whose smoking habits were known, and then following them over the course of years to observe the development of the disease. The need for a large number of participants, and a maximum response from questionnaires, led them to choose doctors as their subjects, because:

- Doctors would be specially interested in the study, and so would answer questions about their smoking habits more willingly and accurately than other groups
- Doctors had to be registered to practice their profession, so they would be relatively easy to follow up.

The choice of doctors as the subjects of the study had further unforeseen benefits, as their concern about the results, with regard to their own health and that of the nation, fuelled the development of tobacco control policy, and contributed to public education about the dangers of smoking.

Over two-thirds of the 59 600 doctors on the register responded, and within just three years, the relation between smoking and lung cancer was confirmed. Statistically significant evidence of a relationship with coronary thrombosis was also observed, and as the study progressed, evidence of the role of smoking in many other diseases was also added.

In addition, the study began to answer some of the outstanding questions that had remained after the initial results, such as whether some people had a predisposition to



Sir Richard Doll on his 80th birthday in 1992. By kind permission of *The (London) Times*.

smoking and certain diseases such as lung cancer; and the extent to which smoking was a cause of cardiovascular disease.

"Is it just fate, doctor?"
"Perhaps some people are predisposed to become smokers, [and] are also more susceptible to lung cancer than those people predisposed to be non-smokers."

The conjecture summarised above was perhaps the most important unanswered question after the initial British doctors study results. It is still heard in many countries, sometimes cited by smokers to justify their continued smoking, and frequently used by the tobacco industry to try to discredit scientific evidence about the dangers of smoking.

The possibility of such a double predisposition was dismissed by the experience of the significant number of doctors who stopped smoking following the publication of Doll and Hill's initial results (and the earlier case-control studies), but who continued to be followed up. Their mortality rates from lung cancer and other smoking-related diseases fell, whereas those of continuing smokers did not; however, mortality from diseases not closely related to tobacco remained similar in both groups.

The doctors were followed up for 40 years, with papers being published as the study progressed. The final report was published in the *British Medical Journal* to coincide with the ninth world conference on tobacco and health in 1994.

Doctors, therefore, were not only pioneers in research into the dangers of tobacco, but also comprised one of the first large groups to become subjects of a prospective study, and to show a significant reduction in smoking rates.

Doctors played an important role in shaping public opinion before the adoption of Sweden's Tobacco Act in 1993. The organisation Doctors Against Tobacco was formed at that time. This photograph was taken at a demonstration by doctors during the parliamentary deliberations over the proposed legislation. From *Tobacco control—Swedish style*. By kind permission of the National Institute of Public Health, Stockholm, Sweden.

Doctors realise that wide-ranging collaboration is required

Following the publication of the first Doll and Hill prospective study results in 1955, doctors started to quit smoking in large numbers. Pressure also began to build up among doctors for effective action to be taken.

Responding to such pressure, the Royal College of Physicians of London (RCP) set up a committee to study the accumulating scientific evidence linking smoking to disease, and in 1962 published its first report on smoking, which received widespread publicity. Doctors then pressed the British government for health education and other action.

In 1964, partly spurred on by the RCP report in the United Kingdom, the first review of smoking evidence by the Surgeon General in the United States was published. Once again, this mobilised large numbers of concerned doctors.

In 1967, the RCP published its second report on smoking, and almost immediately, realising that doctors' advice and action had failed to persuade the government to take effective action, the RCP set up Action on Smoking and Health (ASH), a charity dedicated to public information work against tobacco. ASH exists to this day, and most recently played a crucial part in campaigning for the British government to back the EU directive on tobacco control.

More details about setting up a dedicated tobacco control agency are given in Chapter 10.

Doctors have also been leaders in many European countries, including the United Kingdom, in:

- Lobbying for legislation
- Pressing for tobacco tax rises
- Setting up and supporting special no-tobacco days to be a focus of cessation activities and encouragement.

6 Smoking cessation

This chapter deals with the most direct and personal way in which doctors can help reduce the harm caused by tobacco: helping their patients to stop smoking.

In this chapter

- Doctors have a unique ability to help smokers to stop smoking
- Many smokers want to stop smoking, and others may be receptive to encouragement to stop
- A brief intervention by a doctor has been shown to increase the chances that a smoker will successfully stop smoking
- Nicotine replacement therapy can increase the success rate of more dependent smokers; other techniques may also have a role.

Thousands every day ...

In most countries, thousands of patients attend at family doctors' practices every working day (in the United Kingdom, for example, with a population of 57 million and average smoking rates for the European Region, doctors see about 250 000 patients every day). A sizeable proportion of these will be smokers, who tend to be over-represented among patients presenting with many types of complaint. The daily opportunity for intervention is therefore immense.

Doctors can help

Doctors are in a unique position to help because:

- Their advice on health matters is trusted more than anyone else's
- They see people when they are most susceptible to receiving health advice
- They can personalise their advice by referring to the patient's own health and family history
- They see so many smoking patients every week.

Smokers want to stop

In all countries there are smokers who want to stop smoking. Either they have not yet tried to stop, or they may have tried but failed, sometimes many times.

This "dissonant" group, unhappy about their habit but still continuing to smoke, may account for as many as two-thirds of all smokers.

The following characteristics of many of the smokers who present for consultation with their doctors offer important starting points for the doctor's intervention.

Many smokers:

- Want to stop smoking
- Underestimate and misunderstand the risk, often substantially
- Already have some related symptoms, such as cough, reduced lung function
- Do not want their children to start smoking
- Want to save money
- Have a husband, wife, children, friends, colleagues, who want them to stop
- Do not like the smell and dirt caused by smoking
- Have other cardiovascular risk factors.

People's experience of giving up smoking differs widely—some say they gave up at their first attempt, others that it took them many failed attempts before at last they succeeded. Some experience serious withdrawal symptoms after cessation, others none at all. And a single smoker can have markedly different experiences on each of several different attempts to quit.

This variety of experience is one of the factors that can make it difficult for doctors to know how best to encourage their patients to stop smoking.

By Mel Calman, by kind permission.

As a background to this subject, therefore, it can be helpful to bear in mind a model of smokers' attitudes to their habit, and the psychological stages they typically pass through on the way to giving up smoking for good.

A smoker's wish to stop smoking develops, often slowly, through a number of stages:

- Change in attitude—the smoker feels:
  - *"I should think about stopping"*, and later:
  - *"I really ought to stop"*.

  Many smokers stay at this stage for a long time before moving on.
- A trigger, something that prompts action: this may be something relatively trivial, such as another tobacco tax rise, or a friend or neighbour stopping, or something more personal, such as children appealing to them to stop. Or it might be the illness or death of a smoking friend or relative, or the development of their own smoking-related symptoms. The result is to make the smoker feel:
  - *"Right, now I am definitely going to stop"*.
- Carrying out the decision to stop.

Unfortunately, many smokers relapse and may go round the cycle several times before finally stopping for good. For this reason it is important to avoid talk of success and failure, but rather to keep motivation high, and encourage another attempt.

Studies of attempts to quit show that some smokers need a previous attempt—or attempts—to quit before they are able to maintain cessation successfully.[2 3]

Smokers tend to feel the opposite: they think that because they have tried so hard before (often many times) and have failed, it is hardly worth trying again. But the doctor can encourage them by personalising the reality: contrary to how they may view the likelihood of stopping, their chances of succeeding this time may actually be better than ever.

Intervention by the doctor

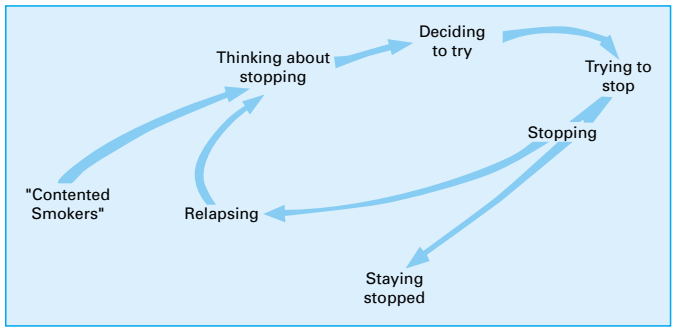
Summary

Doctors can help patients to quit by:

- Reviewing their tobacco habits, even for patients who have never presented with tobacco-related symptoms
- Discussing with all patients regularly (and repeatedly, for those who so far have not taken action) the benefits of quitting
- Regularly encouraging them to quit
- More active counselling for those who agree to quit
- If appropriate, prescription of nicotine replacement therapy
- Follow-up to try to ensure compliance
- Repeating the earlier procedures if patients relapse.

Other simple procedures in general practice have been shown to aid long-term success rates. These include:

- The smoker filling in a questionnaire of smoking habits
- A statement of intention by the doctor to follow up the patient, to check progress
- The doctor handing the patient a simple leaflet about quitting.



The process of stopping smoking. From *Help your patient stop*,[1] by kind permission of the publishers.

There is no magic cure …

It is important to note that there is no magic cure for smoking; that much as some patients want the doctor to make them stop smoking, and somehow even to do it for them, it is only the patients themselves who can quit.

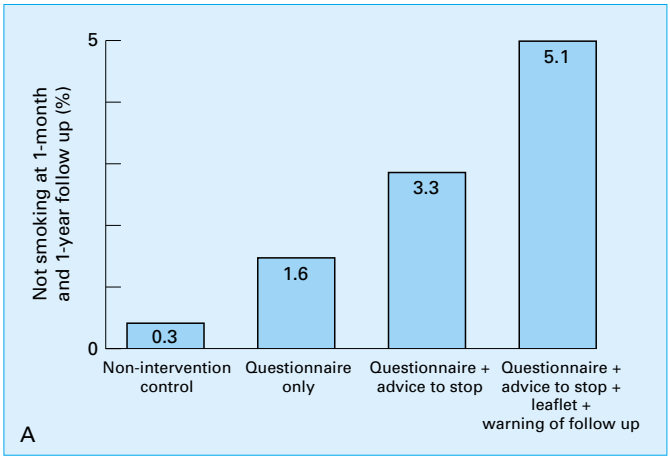
In the past, the overall success rate among people in the general population who try to give up smoking has been disappointingly low—something like 5% still not smoking one year later (the most realistic time to measure long-term success) is about the best that is achieved, apart from selected groups where motivation is much higher.

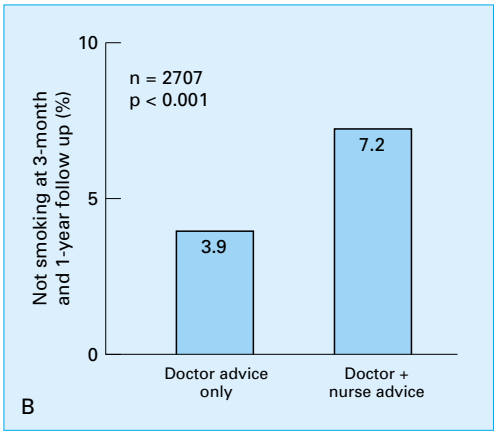
However, this should be seen as a challenge, not a disincentive to act. Moreover, with increasing attention being given to cessation by individual doctors, health care providers, and the pharmaceutical industry, and with new cessation techniques constantly being researched, significantly higher rates may be attained in the future.

Clearly, doctors need to choose carefully how they take account of long-term success rates when counselling people to stop smoking. Above all, they will want to give as much encouragement as possible to all their smoking patients to stop, and to keep trying with those who relapse.

Recommendations for a brief intervention with patients are set out in more detail below.

During cessation follow-up, compliance can be monitored with a carbon monoxide detector. From *Tobacco control—Swedish style*, by kind permission of the National Institute of Public Health,Stockholm, Sweden. Photo: Jacob Forsell.





(A) Effect of general practitioners' advice against smoking (2000 patients randomly allocated to four groups). (B) Nurse-assisted conselling for smokers in primary care. From Flower,[4] by kind permission of Karger, Basel.

The brief intervention

This advice is intended for all doctors, not simply primary health care practitioners. It follows a simple pattern, with one stage leading to the next unless the doctor judges that it is not appropriate to continue on this occasion.

Unless there is good reason not to raise the subject, each consultation should be used at least to ask patients marked as smokers whether they still smoke, whether they have tried to quit recently, or whether they have thought about trying (again) to quit.

> In all consultations with patients, the doctor should be aware whether each individual patient is a smoker. This means that each patient's smoking habits should be recorded in the notes.

The doctor will have to judge whether the patient is receptive to further information and encouragement, and if so, exactly what sort. Assuming the patient is receptive, the doctor can continue as follows:

If the patient seems willing to consider trying to stop smoking, the doctor should:

- Offer information, advice, and encouragement to get the patient to consider converting this consideration into a firm commitment to quit.
- Reinforce the decision to quit
- Hand the patient a cessation leaflet, if available
- If appropriate (depending on availability, and whether the patient has tried to quit before and failed because of nicotine craving), the doctor should offer to prescribe nicotine replacement therapy (NRT), or if it is available without prescription, recommend buying a course of treatment, and give appropriate advice about using it.
- Whether or not NRT is to be used, the doctor should suggest that the patient should plan in advance a day when they will stop for good, and talk briefly and encouragingly about preparing for this step.
- In ending the consultation, or at least this part of it, the doctor should once again reinforce the patient's decision to quit, say that the doctor will follow up the patient's progress, and offer to provide any further help if necessary.

How long with each patient?

Doctors will have a limited amount of time each month to spend counselling patients about smoking, so clearly it is important to find the most effective formula.

- A longer time with fewer patients —

Although a longer intervention can achieve a greater success rate, the increase is marginal.

- A few minutes with more patients —

Research of general practitioner interventions in normal, everyday practice suggests that sessions of just a few minutes per smoker may be optimum.

Each doctor will develop a style, or range of styles, for dealing with patients about smoking. Needless to say, it must be sympathetic, tailored as much as possible to the individual's circumstances, and must not be perceived by the patient as hostile. This is obviously necessary to avoid alienating patients, or deterring them from consulting the doctor.

An over-zealous approach can be counterproductive; to avoid this, an approach which considers how individual patients view themselves as smokers, and how they are likely to react to different styles of intervention, is the most acceptable.[5]

By Larry, by kind permission.

If the doctor feels that time constraints are simply too great for even a few minutes with all potentially receptive smoking patients, then the brief intervention should be restricted to high-risk groups. These will include those with existing chest and cardiovascular conditions, people who smoke heavily or who have been smoking for many years, and pregnant women.

Reference should also be made to the resources listed at the end of this chapter and in Appendix 3.

Nicotine replacement therapy

NRT has been shown to be more effective than other methods of physician-assisted cessation, so it is worth looking at the this range of methods in more detail.

How NRT works

The theory behind nicotine replacement is simple: the person trying to give up smoking gets nicotine temporarily (up to eight weeks) in a pure, non-tobacco form, to relieve the cravings commonly experienced on withdrawal from smoking. During this time they become accustomed to life as a non-smoker. Thus the ex-smoker is spared the difficulties of having to give up both a psychological dependence and also a physical dependence at the same time.

Types of NRT

There are four types of NRT: gum, patch, nasal spray, and inhalator. Not all methods are licensed in all countries, although the gum and the patch, being the longest serving, are probably the most available.

- The patch delivers nicotine to the smoker's bloodstream via the skin, usually being worn on the upper arm, or the thigh or back; and the other methods deliver through the buccal or nasal mucosa
- The gum, available in 2 mg or 4 mg doses, tends to cause a medium blood-nicotine elevation, compared with the peaks that cigarette smoking can deliver. It is used either when needed (typically whenever a cigarette would have been smoked), or at fixed times of the day
- The patch delivers a lower but relatively steady dose all the time it is worn, which is either for 24 hours or during waking hours only
- The gum and the patch may be used together, the patch setting up a relatively constant elevation in blood nicotine, and the gum being used to temporarily raise it further if and when the smoker experiences craving
- The nasal spray and the inhalator are used in the same way, to respond to craving; being more recent products, they have been less thoroughly evaluated in practice.

The Cochrane Tobacco Addiction Group (see Appendix 3) has reviewed available randomised controlled trials in which NRT was compared with placebo or no treatment, or where different doses were compared. The group concluded that the following were the implications for practice:

- All four methods are effective as part of a strategy to promote smoking cessation
- They increase success rates by two to three times regardless of setting
- They should preferably be directed to those who are motivated to quit and have high nicotine dependency
- There is little evidence about the role of NRT for people who smoke fewer than 10–15 cigarettes per day
- Which product to use—choice should reflect patient needs, tolerability, and cost considerations; patches likely to be easier to use in primary care settings
- 8 weeks of patch therapy is as effective as a longer course; abrupt withdrawal as effective as tapered therapy
- Wearing a patch only during waking hours is as effective as wearing it for 24 hours
- Gum may be used either when need is experienced, or on a fixed dose basis. Those who fail with 2 mg gum should be offered 4 mg gum.

What about the cost?

In countries where tobacco tax is relatively low, making cigarettes cheap, patients may feel that the cost of NRT is high. Doctors will want to emphasise that it is only a temporary expense, and that in the long term, patients who give up smoking will save money.

In countries with high tobacco tax and therefore high cigarette prices, the cost of NRT, albeit temporary, may be comparable to the average cost of smoking. Doctors can use this point to encourage patients to buy and use the treatment.

How much support is needed with NRT?

The effectiveness of NRT appears to be largely independent on the intensity of additional support offered to the smoker, though all trials reviewed by the Cochrane group included at least some form of brief advice to the smoker. This is therefore the minimum that should be offered to try to ensure effectiveness.

Provision of more intensive levels of support, although beneficial in facilitating the likelihood of quitting, is not essential to the success of NRT.

Nicotine: only the least dangerous forms are regulated

NRT is regulated in the same way as other pharmaceutical products.

Cigarettes are the most efficient way of getting nicotine into the bloodstream, yet despite delivering thousands of other chemicals at the same time, they are still largely unregulated.

The tobacco industry has worked hard over many years, usually by discreet lobbying activities, to ensure that its products are specifically excluded from regulations governing poisons, chemicals, environmental pollutants, or other dangerous substances.

NRT in Georgia

In 1997, the Georgian Medical Association received a donation of over 5000 units of nicotine patch treatment, and distributed them to more than 20 medical institutions over three months, with an evaluation form for those prescribing them to measure success rates.

Other techniques

Group counselling has been shown to be the most cost effective use of the doctor's time in the United States, but it depends on getting the patients to join and to stay in groups. It may be worth pursuing this method with existing groups of

smokers who want to quit, or where such groups can easily be formed, but for practical or cultural reasons, group counselling may have limited relevance in other settings.

A summary of other interventions, based on the Cochrane group's examination of the literature on smoking cessation, is set out below:

- Acupuncture: appears mainly to act only as a placebo in smoking cessation
- Future research should concentrate on whether acupuncture can lead to a reduction of nicotine withdrawal symptoms
- Anxiolytics: no evidence that they are likely to aid smoking cessation
- Antidepressants: there is promising evidence suggesting that bupropion may be more effective than NRT (either alone or in combination). However, further study is needed to determine the most appropriate way of using it for smoking cessation, and antidepressants are not recommended as first-line therapy in preference to nicotine replacement
- Lobeline: no evidence is available from long-term trials that it can aid smoking cessation.

Working with other health professionals

It is important to realise that not only doctors, but other groups of professionals associated with health care often have opportunities to counsel and assist smokers to quit.

Nurses, (including practice nurses), physiotherapists, health visitors, midwives, pharmacists, dentists, and others are all potentially valuable in this role.

Individual doctors, and also the NMA, should try to include representatives of these health workers in education and training about smoking. The development of awareness about tobacco by these groups will in any case be facilitated by their national training and membership organisations becoming involved as members of a national coalition on tobacco control, as recommended in Chapter 10.

Useful resources

Helpful examples and advice on cessation work can be found in:

- Raw M, *et al.* Smoking cessation guidelines for health professionals. *Thorax* 1998;**53**(suppl 5):S1–19.
- White Paper on tobacco of the British Government: www.official-documents.co.uk/document/cm41/4177/4177.htm
- World Health Organization. *Third action plan for a tobacco-free Europe 1997–2001*. Copenhagen, Denmark: WHO Regional Office for Europe, 1997. (Document EUR/ICP/LVNG 01 04 01.)
- Raw M. *Help your patient stop*. London: British Medical Association and Imperial Cancer Research Fund, 1988.
- Raw M. *The physician's role. Smoke-free Europe 1*. Copenhagen, Denmark: WHO Regional Office for Europe and Commission of the European Communities, 1987.

Other, unproven cessation methods

Apart from NRT, there are many cessation methods for which success has been claimed, ranging from herbal and chemical preparations supposed to reduce craving, to hypnotherapy; from dummy cigarettes to acupuncture. These methods are not dealt with in detail here, as most of them have received no serious evaluation, or have been found to be relatively ineffective.

Many doctors encounter ex-smokers who are convinced that one of these methods worked for them when all else failed, and to some extent that may be true for certain individuals. It does not mean that doctors should recommend them as effective, nor necessarily dissuade a patient who is keen to stop smoking from trying one of them.

More important is to try to reinforce the patient's decision to try to quit, and to provide education and information to maximise the chance of success; but this may mean carefully addressing any false hopes the patient may have that a miracle cure is at hand, and ensuring that if possible, the doctor can cover the recommended routine procedures and consideration of NRT during consultation and counselling.

References

1 Raw M. *Help your patient stop*. London: British Medical Association and Imperial Cancer Research Fund, 1988.
2 Hymowitz N, *et al.* Predictors of smoking cessation in a cohort of adult smokers followed for five years. *Tobacco Control* 1997;**6**(suppl 2):S57–62.
3 Jaén CR, *et al.* Patterns and predictors of smoking cessation among users of a telephone hotline. *Public Health Rep* 1993;**108**:772–8.
4 Fowler G. In Bollijer CT, Fagerström K, eds. The tobacco epidemic. *Prog Respir Res* 1997;**28**:167.
5 Butler C, *et al.* Qualitative study of patients' perceptions of doctors' advice to quit smoking: implications for opportunistic health promotion. *BMJ* 1998;**316**:1878–81.

7 Tobacco control: action for doctors at the local level

Apart from encouraging doctors in cessation work with patients, national medical associations will want to ensure that their members take individual action in other ways, in the wider community, as summarised in this chapter.

In many countries, it will not be practicable for all doctors to take action on all the points suggested below. However, NMAs might suggest that local branches try to nominate one doctor to take a special interest in tobacco, and work towards action on as many of the ideas as possible.

In this chapter

- Teenagers: consider calling in all teenage patients for supportive discussion about health problems (including tobacco), laying down the basis for an adult patient relationship. Schools may offer opportunities for more public discussions with children about smoking
- The local community: doctors can influence tobacco control policy at the community level across a wide range of issues. Press and media work can be particularly effective
- Politicians: get to know local politicians and other decision makers; educate them about tobacco, especially in the clinical setting; press them to take action; coordinate with press activities as part of the wider campaign
- Professional advisory roles: doctors who hold professional appointments or consultative status within occupational health, environmental or public health, or with local government, have special opportunities for action
- Scientific research: doctors can influence research funding to support tobacco control efforts. Special responsibilities arise if tobacco industry funding of research is proposed.

The alluring image of smoking

The image of tobacco, especially cigarettes, has been deliberately cultivated by tobacco companies to be adult, and to be associated with glamour, sporting success, and a host of other positive images that are particularly attractive to adolescents as they struggle to assume their new, adult, "cool" personas. This image is constantly reinforced by advertising, sponsorship, and many marketing activities, including deliberate involvement with the fashion industry and with popular music.

To be seen smoking at a disco, young people may feel, is like wearing a badge of acceptance as a young adult, safely removed from the childhood image they want to shake off.

Teenagers

Studies in many countries have shown that adolescence is the critical time for childhood experimentation with tobacco, and for regular tobacco use to begin among those who are later to be regular, adult smokers.

Most smokers begin their habit as children, not as adults. The majority of these child "starters" (the cynical word used privately by tobacco companies) begin smoking during adolescence.

In western Europe, the transition from early childhood into pre-teens and teenage life, most obviously marked by transfer from primary school to secondary school at around 11 years of age, appears to be the most dangerous time for tobacco use to begin. From being at the top of their first schools, children are suddenly the most junior in a new school, full of bigger, more grown-up children.

Doctors may wish to discuss smoking as early as possible with teenage patients, and to encourage the teenagers' parents to do the same, in an understanding way, and to consider entering into agreements with their children about abstinence from tobacco. This may help to prevent smoking uptake, aid cessation early on, or simply plant the first seeds of an intention among an important segment of the population not to smoke.

Some doctors may explore the benefits of visiting schools and colleges, to discuss smoking with students, staff, or parents groups.

There are opportunities for useful research to explore the effects of doctors' contact with teenagers with regard to smoking, an area in which there have been few contributions so far.

The local community

Apart from their professional activities, there are many opportunities in any local community for doctors to contribute to the fight against tobacco. This may be via local media, through their work with local organisations, such as cancer, heart, and lung organisations, or as members of groups such as school boards, local government committees, and residents' associations.

Many of the initiatives in which doctors might participate at community level are local versions of national action by

Teenage study
In a study[1] in British family doctor practices, a special consultation was set up with teenagers, with their parents' consent where required or appropriate. Unexpectedly large numbers (67%) came in for a talk with their family doctor or general practice nurse about a range of teenage health issues, including smoking. Of those who smoked, 60% entered into an agreement with the doctor or the nurse to try to stop.

Follow-up work is in progress. The pilot study suggested that for many doctors and young patients, this was the first time they had met, other than during a brief consultation. The teenagers responded encouragingly to being approached in an adult, friendly way, and openly discussed issues such as the pressures on them to smoke—for example from peers and older siblings, and at social gatherings.

A contract to stay tobacco-free
Anecdotal evidence suggests that it can be helpful if an agreement is reached with pre-teenage children, under which the parents offer to reward the child with some benefit (perceived by the child as substantial) if, on attaining a certain age—perhaps 18 or 21 years—the child has not smoked. Such arrangements need to be discussed carefully, openly and regularly. They are probably strongest when children understand why their parents are so keen that they do not grow up to be smokers, and when the agreement contains a provision for discussing any occasional and temporary lapse.

Adults who avoided smoking this way during their own childhoods report that apart from their personal interest in the reward, its existence was also impressive to their peers, including the smokers. Instead of being branded as unadventurous or cowardly, the young non-smokers were envied and respected for having the reward to look forward to. It was therefore an effective protection from pressures to smoke.

medical associations, which are outlined in Chapter 10. Others may be specific to the community.

Some examples of local initiatives are:

- Campaigns for smoke-free schools, hospitals, restaurants, offices, shops, and premises used for leisure activities
- A special day to encourage and help people to stop smoking, usually as part of a national campaign
- A campaign to persuade local government to ban tobacco advertising on its property, or on public transport
- Campaigns to increase compliance with existing laws, such as a ban of sales to minors
- Campaigns against local tobacco sponsored events—for example, sports and discos.

In their work at community level, doctors must capitalise on people's perception that they are the most reliable experts on medical issues. This may seem obvious, but it is not always fully appreciated or used to full effect by doctors. Moreover, many people do not realise how low certain other professional groups are rated as credible sources of information. Doctors' influence is especially important in press work.

"Experts"
As the pervasiveness of mass communications continues to increase, with a commensurate increase in opinions being heard from people described as "experts" on one side or another of various topical issues, public cynicism—or at least a suspension of trust in everything heard—is likely to increase. Few commentators on many contentious issues may be perceived as neutral, so their opinions may not lead to individual members of their audience giving their views much consideration. But doctors have a major advantage, as they tend to be perceived as being primarily interested in people's health, and therefore not swayed by commercial considerations, unlike those who profit from tobacco. This should be stressed by doctors in their communications with the public.

Doctors, the press, and broadcasting media
Among the most effective use of doctors' time spent as advocates in the local community will be initiatives involving the local press and broadcasting media. Media representation will be an important component of many local initiatives—for example, an interview with a doctor will give scientific credibility to a local group that is campaigning for non-smoking to be the norm on public transport, or in public places.

Politicians

One of the most direct ways for doctors to turn their intentions into actual results in the community, is to persuade the people with the power to change things, notably local politicians, to adopt tobacco control policies.

The Turkish version of a World Health Organization poster campaign "Tobacco or health? Choose health". From a book on doctors and tobacco, *Hekim ve sigara*, published by the Turkish Medical Association.

Letters
Writing letters can be useful, especially when the problems expressed are translated into local dimensions.

Statements about national disease and mortality rates from tobacco may seem somewhat remote, especially from the everyday experience and concerns of the politician. Compare these two statements:

> *"According to our chief medical officer, 100 000 people in this country die prematurely every year because they smoked."*
>
> and
>
> *"More than 150 voters in your area will die prematurely this year, from smoking diseases."*

The second statement is much more meaningful to a politician.

Personalising the message
Wherever possible, a doctor's conversation or letter to a politician should personalise the realities of tobacco, relating them to the doctor's own, recent experience. Some examples:

- *"Only this morning, I saw a patient who …"*
- *"Every time I take an outpatient clinic, I see people needlessly suffering …"*
- *"I keep having to admit patients to scarce hospital beds because of entirely preventable conditions …"*

Not only is such an approach more powerful than the mere repetition of statistics, but also politicians find it more helpful. It allows them to relay what they learn to their colleagues, in business meetings or in debates, in a more persuasive way.

"The full force of medical opinion"
How politicians may perceive letters from doctors:

One letter: "A letter from a doctor."

Two doctors' letters on the same topic:"There seems to be increasing concern among doctors".

Three doctors' letters: "This is obviously what the medical profession thinks about this issue."

It is helpful to get to know politicians personally before any specific campaign begins.

A clinical setting is best for talking to politicians. A general meeting to get to know the politician does not rule out a special meeting later about a specific campaign.

Invitation to a politician
It is difficult for an elected representative to refuse an invitation to a local hospital, or to meetings with family doctors, as politicians are so often contacted by voters about health issues.

The invitation is more attractive if the politician thinks favourable press coverage may result, especially with a photograph.

So, invite the politician to a meeting where the doctor(s) can explain the harsh realities of the tobacco problem. Consider inviting him or her:

- To visit the local hospital, or the family doctor's practice office
- To attend part of a regular meeting of medical staff.

A hospital visit could include:

- Talking to chest, heart, and cancer physicians who care for patients with diseases caused by tobacco
- Physicians who could explain radiographs
- Surgeons who could discuss their work in the operating theatre when smokers undergo operations as a result of their smoking.

This sort of exposure can have a profound impact on a politician, whose normal working environment is an office far removed from the results of smoking, which doctors have to face every day.

Put them on record!
If a meeting with a politician relates to a special campaign, it is important to coordinate it with press activities, to get maximum coverage, and to ensure that the politician is put firmly on record as having been lobbied on the subject of the campaign.

Doctors in professional advisory roles

Among the most productive opportunities for making a difference in the community on tobacco control issues arise from doctors holding appointments in:

- Occupational health
- Environmental health
- Local government, including authorities responsible for running education, public transport, sports and recreation activities
- Labour unions
- Press and broadcasting.

Doctors who regularly write medical and scientific columns in newspapers, or who appear on radio or television, are also in a strong position to educate the public about tobacco and to influence public opinion on specific aspects of tobacco control policy.

Occupational health
Occupational health doctors can ensure that the issue of smoking is addressed at all levels in a place of employment, that can set in motion a programme to ensure that as much as possible is achieved both for the smoking staff and also for the non-smokers. In particular they can:

- Use their authority to ensure that senior management, occupational health nurses and personnel managers are educated about tobacco
- Devise a programme to cover all staff
- Make staff aware of the risks of smoking, including those for non-smokers
- Encourage smoking staff to quit smoking
- Set in motion a process to develop a non-smoking policy in every worksite.

There are many options to consider, such as whether to recommend to managers that staff who smoke may be allowed some time off work to attend cessation activities, or whether some financial incentive is offered to those who quit.

Staff publications should be used whenever possible to focus on the problem of smoking. In all such activities, as with the process of working towards a non-smoking policy (see Chapter 9 and Appendix 1), the emphasis should be positive and pro-health, with repeated clarification that the employer is concerned about the health and welfare of the workforce.

From a book on doctors and tobacco, *Hekim ve sigara*, published by the Turkish Medical Association.

On no account must the doctor or other organisers give the impression of being anti-smoker; instead, their position should simply be anti-smoking, or more precisely, anti-disease (caused by smoking).

Environmental health and local government

Doctors employed in environmental health, or who advise any level of government on health issues, are in a strong position to influence public policy about tobacco.

Apart from the obvious area of smoking in public places, their positions may also allow them to influence policies on advertising and promotion of tobacco. For example, many city councils and other local government authorities control billboard space, and own public buildings and other sites which tobacco companies may want to use for tobacco promotions.

A strong representation from a medical advisor can set in train moves to prohibit any of the city's property being used for tobacco promotion. In addition, especially in a country in which little has been done at national level to ban tobacco promotion, it is likely to gain publicity, and so can spread knowledge and encourage a positive climate for more widespread tobacco control.

Doctors advising local government may also be able to influence policy covering a much wider range of activities. For example, there may be local government officials in various different departments with authority over many aspects of daily life, including:

- The inspection of restaurants and bars, places of employment, and shops
- Enforcement of laws banning the sale of tobacco to minors
- Regulation of educational establishments, health premises, public transport.

In these areas, a strong lead by the medical advisor can help to develop policy improvements. It will also provide non-medical staff and politicians with the supportive backing of a medical authority, an important aid in all tobacco control initiatives.

Scientific research

In higher education and in other fields of employment doctors may be crucial in influencing decisions about research funding.

Despite the vast amount of research already carried out on tobacco, there is always more to do. Those who allocate research funds may not realise the scale of the tobacco problem, or why it is important to monitor the effectiveness of tobacco control measures. Equally, they may regard research into how the tobacco industry promotes its products as less deserving than, say, laboratory research into a rare disease.

Doctors engaged in research can further the cause of tobacco control in many ways, including:

- Ensuring that research grant makers are aware of the need for tobacco research
- Monitoring tobacco use among population groups, and the incidence of tobacco-related disease
- In public information and education work, as experts explaining research findings about tobacco
- Monitoring and retaliating against tobacco industry abuse of science.

Tobacco industry abuse of science

Instances of tobacco industry abuse of science are now well documented, especially by large numbers of internal industry documents made public during court cases in the United States. They include plans to create a false body of scientific data—for example, to try to "prove" that passive smoking is not harmful; infiltration of apparently independent scientific bodies; and secret manipulation of ostensibly independent international conferences on air quality.

Tobacco industry funding of research

Another area in which doctors can influence tobacco control is in connection with the serious problem of the funding of research by the tobacco industry. Tobacco companies sponsor university departments and research units:

- To buy prestige and political favours
- To neutralise the effects of research showing the harmfulness of tobacco
- To tie up research staff on work not related to tobacco, who might otherwise be investigating it.

For the love of knowledge?

A tobacco company's reasons for funding research not related to tobacco must be to ultimately maximise sales of tobacco: in fact, to do it for altruistic reasons would be an inappropriate use of shareholders' funds.

What doctors can do

Doctors can be powerful advocates in resisting and exposing the potential damage to public health of academic

institutions accepting tobacco money. They will find assistance from colleagues in other countries who have fought similar battles.

Doctors involved against their will in tobacco-sponsored work may not feel able to raise their objections in public, but they may need support and advice. They should approach their medical association to make it aware of the problem, and to ask for help.

Doctors whose professional colleagues are involved with tobacco money can appeal to them to raise the matter with the medical association, and with any other appropriate authorities.

Code of practice

A code of practice on tobacco funding of research has recently been developed by one of Europe's largest cancer research charities, the Cancer Research Campaign in the United Kingdom. The code is being circulated widely to government and voluntary agencies which fund scientific research. Its aim is to try to keep scientific research as free as possible from any tobacco industry infiltration which is hostile to health. This may serve as a basis for use in many other European countries. A copy of the code is attached as Appendix 2.

Reference

1 Townsend J, Wilkes H, Haines A, *et al.* Adolescent smokers seen in general practrice: health, lifestyle, physical measurements and response to antismoking advice. *BMJ* 1991;**303**:947–50.

8 Education and training

In this chapter
Training is not essential for any of the actions recommended in this book, but it can be helpful; the emphasis should be on exploiting opportunities, especially with regard to:

- Smoking cessation
- Medical students
- Continuing medical education (CME) and continuing professional development (CPD)
- Media training, especially for tobacco group leaders and key spokespersons.

Training

There are obvious benefits in training NMA personnel and other doctors in aspects of tobacco control, and in cessation counselling, but much effective work can be carried out with the use of common sense and basic information.

Training health professionals to provide smoking cessation interventions has been shown to increase the amount of cessation work that they do, and to have a modest effect on patient outcome.[1]

National and international bodies such as cancer and heart organisations, and the World Health Organization, develop training course materials, and as NMAs become more closely involved with the international tobacco control community, they will soon learn what is on offer.

Special training opportunities tend to be offered at large international conferences with tobacco or tobacco-related diseases as a major theme. Increasingly, training sessions are being attached to such conferences, sometimes running in parallel to the main conference, and sometimes held during additional sessions before or after the main meeting.

Conferences where such opportunities occur include the world conferences on "tobacco or health", which are currently held every third year; the major international and regional conferences on heart disease, lung disease, and cancer; and various WHO and medical association meetings. Increasingly, too, funding is being built into the budgets of these meetings for bursaries for representatives from countries with lesser resources.

Seeking and taking opportunities

As with much in tobacco control, emphasis should be placed on taking every possible opportunity to increase the skills and experience of all doctors, and of leaders of the NMA's tobacco control efforts in particular. Some specific examples are reviewed below.

Smoking cessation

Much debate—and research—has taken place around the world about effective ways of trying to maximise the numbers of doctors helping their patients to stop smoking. These have involved various training options, service payments, more and less elaborate counselling sessions and materials, various cessation aids, especially nicotine replacement products, and group counselling sessions.

Not all of these are appropriate in general practice in all countries. For example, service payments to the doctor for counselling patients, however justified in terms of long-term cost effectiveness, do not seem to be a realistic option for many countries at present, especially where state health care resources are severely restricted. Training may help to give the doctor confidence, and may therefore increase the number of interventions attempted, but may add only a little to overall success among the patients.

Spanish smoking cessation guide for health professionals.

A guide to smoking cessation practice is set out in Chapter 6; and ways that the NMA can assist doctors to acquire cessation information and skills are included in Chapter 9.

Medical students

The book *Educating medical students about tobacco: planning and implementation*,[2] is a comprehensive publication on this subject, giving detailed information and advice.

The approach taken by the book is to be recommended: this subject is not intended to be an additional burden on the medical curriculum, but simply an aid to teachers to ensure that tobacco is adequately covered.

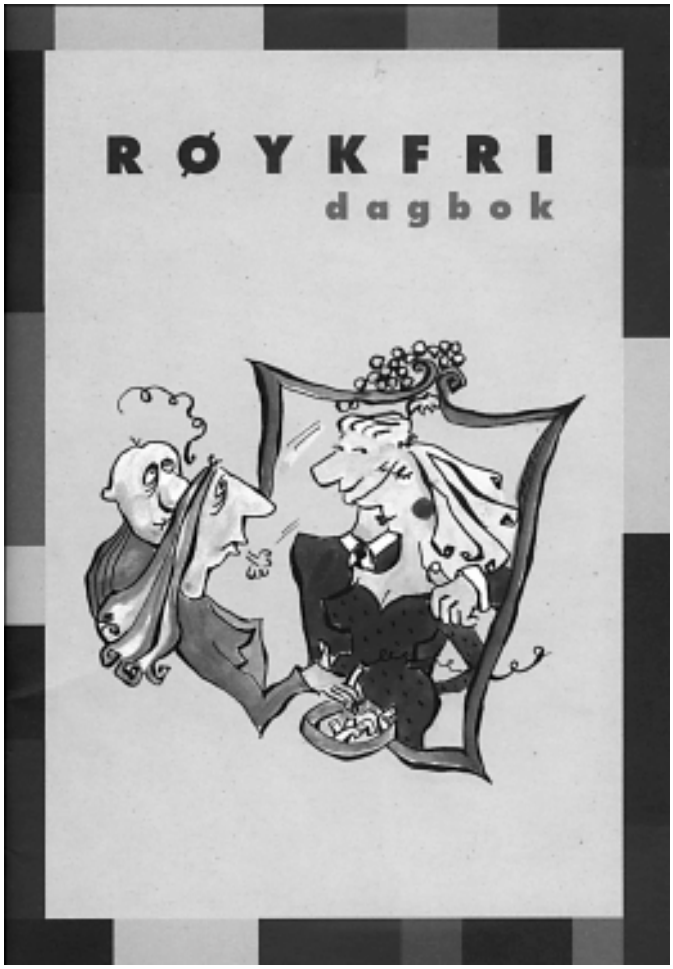
Suggested action within medical schools is covered at the end of a checklist given in the first chapter. The suggestions in this section are reproduced here, summarising action to ensure that the next generation of doctors appreciate the importance of tobacco as a cause of disease.

Suggested action within the medical school

- Appoint a coordinator of tobacco education
- Consider an initial survey of:
  - medical students—suitable questionnaires are available from WHO and the International Union of Against Tuberculosis and Lung Disease (IUATLD)
  - staff attitudes—preferably, a questionnaire to be designed locally.
- The coordinator should produce a written policy in consultation with relevant colleagues, covering:
  - smoke-free medical school premises
  - smoke-free medical hospitality areas
  - teaching in relevant departments—suggest a checklist for each relevant department
  - examinations—ensure that tobacco problems are covered in theoretical and clinical examinations (ensure that a smoking history is always recorded by the student)
  - methods proposed for monitoring students' progress
  - the value of giving a brief talk to new medical students on their first day in the faculty, explaining the importance of smoking as a major preventable cause of disease and the importance of their personal example as doctors and non-smokers
- formal review: the faculty should formally review progress one to two years after initiation of the programme.

Continuing medical education and continuing professional development

Doctors, like other professionals, need to update their knowledge and skills throughout their careers to maintain their competence. Continuing medical education (CME) is regarded as scientific and technical upgrading, whereas continuing professional development (CPD) can be viewed as the wider development of a doctor's established medical knowledge. This includes the personal, social, and political aspects of medicine and public health.



Norwegian *Smoke-free diary*, a day-by-day smoking cessation guide.

The increasing attention currently given to CME and CPD provides an ideal opportunity for doctors to learn about the many aspects of tobacco control. A small degree of success by a single clinician in achieving smoking cessation can result in a considerable reduction in morbidity and mortality when extended nationwide. Therefore CME and CPD, which raise doctors' awareness and increase their activity in tobacco control, can make a significant difference to health.

"Weigh up the pros and cons (of quitting)." From a smoking cessation booklet published by the Institute of Health, Spain.

Continuing to learn and to develop their ideas on tobacco-related issues can help doctors to maximise the effectiveness of their work with individual patients, to influence those who smoke to stop smoking, and to reinforce the behaviour of non-smokers, especially the young.

Media training

NMAs can fairly easily provide training for those who will represent the association in press interviews. Such training should cover the general principles of health advocacy, as well as the basic essentials of tobacco control. It may do this in collaboration with other bodies, especially that which have members experienced in tobacco control. Help can also be obtained from a variety of journalists well disposed to the NMAs' tobacco control work.

A key topic for training should include responding to the tobacco industry's standard strategy of changing the agenda in any discussion about tobacco and disease (trying to avoid discussion of disease, and concentrating only on its own version of short-term economic or commercial issues). A valuable part of such training can be a simulated television debate about tobacco.

The training faculty should include, if possible, at least one person with experience of debating against people with tobacco interests, on radio, television, or at meetings; or anyone, perhaps from a consumer group, experienced in opposing those with vested interests in other industries that sell controversial products. The tactics the tobacco industry uses, and therefore the techniques required for answering them, are often very similar.

Training: simulated television debate

Role play can be a valuable part of media training. Realistic experience can be gained by simulating a live television debate. One person will play the part of the television presenter moderating the debate, and two others will be briefed to play the parts of a tobacco industry executive and a health advocate. The remaining participants, the "studio audience", will be asked to play roles that are either pro-health or pro-tobacco industry.

After interviewing each of the two leading speakers for, say, three minutes, the presenter then opens the debate to the rest of the "studio" and then, after 10 or 15 minutes, returns to give each main speaker just one minute to summarise their case.

Valuable experience can be gained of dealing with tobacco industry tactics, and of presenting a health case as clearly as possible in the minimum time.

References

1 Lancaster T, *et al.* Training health professionals in smoking cessation (Cochrane Review). In *The Cochrane Library*, issue 1. Oxford: Update Software, 1999.

2 Richmond RL, ed. *Educating medical students about tobacco: planning and implementation*. Paris: International Union Against Tuberculosis and Lung Disease, 1996.

9 Increase doctors' awareness: action for medical associations

This chapter sets out ways in which national medical associations can fulfill their role in raising the awareness of individual doctors about tobacco.

It outlines action directed towards the NMA's own members, as opposed to the next chapter, which covers action directed outside the NMA.

In this chapter

- Carry out a survey of doctors' smoking habits and attitudes to smoking
- Disseminate the results of the survey
- Set up a tobacco group in the NMA
- Educate the membership about tobacco
- Make the NMA's premises smoke-free
- Make use of the medical press
- Brief doctors about smoking cessation
- Support doctors' cessation activities.
- Review an NMA's investment portfolio to eliminate tobacco holdings.

Survey of doctors' smoking rates

The idea of surveying members has been described in detail in previous publications, including *The physician's role*, the first publication in the WHO Smoke-free Europe series (See Appendix 3). Reference should be made to this for detailed guidance.

If doctors' awareness is already high

If doctors' awareness about tobacco issues is already high, this does not mean that the subject should be ignored. There is always more to learn that will affect doctors' roles in the continuing fight against tobacco:

- New scientific research findings
- New developments in cessation
- New policy developments

There will always be new doctors qualifying, who need to be educated about tobacco.

If doctors' awareness is low

In some countries, there will be fewer doctors who understand the larger picture of tobacco. The scientific evidence, the politics and economics of tobacco, the way tobacco promotion works, and other key issues will need to be included by the NMA in a more thorough and wide-ranging programme.

Why measure doctors' smoking rates?

It is important to know how doctors use tobacco: regular surveys can measure progress, but also:

- If doctors' smoking rates are low, this can be used by the NMA as an example to the general public
- If doctors' smoking rates are high, this indicates that priority must be given to the problem.

Doctors' attitudes to tobacco

A survey that records attitudes as well as behaviour can illustrate demand from doctors for action and guidance, and thus guide the NMA about what it should be doing to help members maximise their work on tobacco.

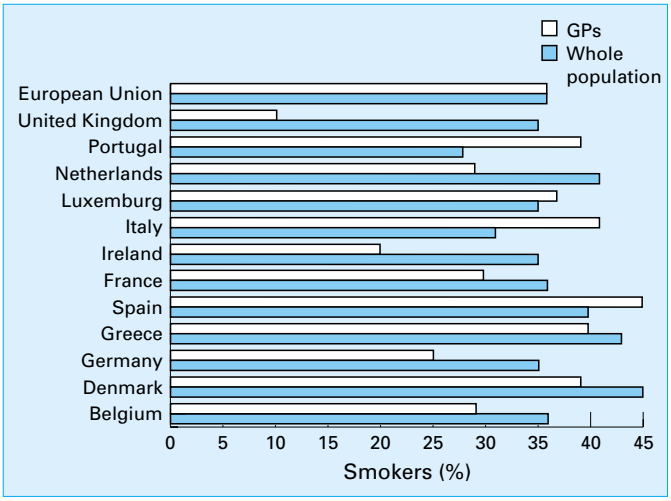
It is strongly recommended that such surveys are carried out regularly. To ensure that maximum benefit is obtained, it is essential to involve experts, such as a good statistician, in designing the questionnaire and methodology.

The Swedish experience

Swedish doctors' smoking rates and attitudes have been measured for almost 30 years, using a random sample of 5% of the profession, and yielding valuable information. In this time, the percentage of daily smokers fell from 46% to 6%, and among those who did smoke, the number of cigarettes smoked per day fell from 13 to five. Interestingly, among the reasons cited for not smoking, "being a role model" increased from 10% to 71% of all doctors. General practitioners now smoke the least (4%) and psychiatrists the most (11%).

Disseminating the results of the survey

How the results of the survey are disseminated will to some extent depend on their nature. The NMA will want to consider:



Proportion of general practitioners (GPs) in the European Union who are smokers compared with the general population. From Fowler,[1] by kind permission of Karger, Basel.

- Informing NMA members
- Publishing the results in the NMA's own publications
- Informing the external medical press
- Publishing the results in all media
- A special conference or seminar to coincide with publication, to consider trends and issues of smoking among doctors.

If much work is still needed

Provided that the NMA has taken a firm decision to address the smoking problem, it should not flinch from publishing the results, especially in the medical and scientific press. Positive use can be made of a survey revealing high smoking rates—the NMA should explain that the survey:

- Justifies the NMA's decision to act
- Shows that it is putting its house in order
- Shows the dependency upon tobacco, if even doctors—who daily see the harm caused by tobacco—are still battling to give up
- Illustrates why the problem must be taken seriously by the government.

If the results show good progress

Low smoking rates, or a significant improvement over a previous survey, may lend themselves to more widespread publication.

Explaining doctors' smoking

Care must be taken in publishing details of doctors' smoking, as any smoking at all among doctors may strike a cynical outsider as evidence of hypocrisy when doctors or their NMA seek to encourage the general public to quit. Nevertheless, with the right handling, and with recognition of the addictiveness of tobacco to many smokers, any results can be used to promote valuable messages about tobacco. A significantly lower smoking rate among doctors than among the general population can be used to reinforce other messages about the harmfulness of smoking, and to increase the climate of opinion in favour of stopping.

Set up a tobacco group

The process of converting a general interest by some members, or at the secretariat, into an ongoing programme may start for a number of reasons, such as:

- Resolutions passed at members' meetings
- Personal commitment of the president or chair
- Pressure from concerned members
- An article in the NMA's journal.

Ensure that women and minority interests are well represented in the group. They will not only bring relevant ideas, skills, and contacts, but will enhance its credibility within the NMA and outside.

Typically, those who come forward to answer a call for action include specialists who daily see the consequences of smoking: cancer, heart, and respiratory physicians, vascular surgeons, public health doctors, and epidemiologists.

Such specialists are likely to be at the core of a tobacco group, but they can succeed only if they have formal NMA authority to plan and implement the various stages of action.

Long campaign, *big* commitment

At the outset, it is important to realise that tobacco control takes a long time to set up and implement, and that it is a surprisingly complex subject. Much learning will be necessary by those leading the programme, and therefore commitment will be required—of the organisation and those actively involved. If it is to be effective, this will not be a campaign that can be undertaken only for a year or two and then wound up. Commitment by the NMA, therefore, is essential, and should include the highest echelons of its office holders and its most prominent members.

The NMA's membership (or its senior management committee, acting on membership authority) will need to:

- Sanction the setting up of the group
- Approve a budget (if any)
- Agree that tobacco control is a major item within the NMA's work programme
- Agree the terms and scope of the tobacco group's work
- Fix procedures for regular reporting to NMA committees and membership.

Support from the top

For the new tobacco group to be effective, the office holders and senior officers will need to be broadly sympathetic to its aims. An early goal should be the recruitment of some of them to the group, even if other claims on their time mean that they cannot become deeply involved in its work.

Planning the group's work

In countries with relatively little tobacco control history to date, one of the tobacco group's first priorities will be to consider activities to educate the membership about tobacco, including the topics outlined in this chapter.

In countries with an established history of doctors' involvement in tobacco control work, although the education

of the membership should still be reviewed and a programme developed and implemented, the priority may lie more towards the sort of action summarised in the following chapter, in which the NMA directs its energies outwards, to the rest of the country.

Educate the membership about tobacco

In all countries, the education of the membership about tobacco issues will be an important and ongoing task and the responsibility of the tobacco group.

For some NMAs, especially in countries with little tobacco control history, the education of members may be the largest task ahead for the foreseeable future.

In countries with more tobacco control experience, the overall theme of membership education may be to maintain as high a profile as possible for tobacco in all the NMA's work. In particular, the tobacco group will want to ensure that members, especially newly qualified doctors, inform themselves about tobacco, and that clinicians are encouraged to undertake smoking cessation work with patients.

What type of education programme?
Certain formal programmes may be initiated, depending on a wide range of local circumstances. In addition, the following tips may be helpful:

- The tobacco group will want to keep alert for any opportunity that presents itself, such as meetings and training courses, to add to members' knowledge about tobacco
- Full and regular use should be made of the NMA's own publications, for publishing articles about tobacco
- Whenever possible, tobacco should be on the agenda of all NMA meetings.

Publicity breeds help
There will be many NMA members, particularly those who are in the front line of treatment of smoking-related disease, who will welcome publicity about tobacco in the NMA's publications and in other media. It will tend to make them come forward to offer their energies to the NMA's work against tobacco.

"Why all this fuss?"
At first there may be some members or staff of the NMA who think that a major commitment to take action on tobacco might not be deserved. They may fear that it will open a floodgate of demand from those interested in other issues. They should be reminded about the unique scale and character of the tobacco problem. Leaders of the tobacco group will soon find ways to ensure that members understand why tobacco has become such a major issue for the NMA, and know that they can continually gain information about it, and can acquire skills with which to play their part.

Make the NMA's premises smoke-free

Banning smoking in the NMA's own premises, and at all meetings held under its auspices, is a practical and symbolic action already taken by many NMAs in Europe.

The tobacco group should draft and publicise guidelines to ensure that smoking will not be permitted:

- In any of the NMA's premises
- During any NMA meetings, in any location
- In any meetings held by other organisations in the NMA's premises
- In meetings jointly sponsored by the NMA and other bodies.

Basic steps to a non-smoking policy
The approach to be taken may vary slightly from country to country, in line with employment law, but overall the approach will be similar.

- The medical association should appoint a coordinator who should have the skills and authority to handle the process of negotiating and implementing the policy
- A workin ing force for the proposed change should be that of a "health and safety at work" issue, just like other important issues in this category—for example, removal of asbestos building materials.
- The minimum overall objective should be to guarantee non-smokers the right to breathe air free from tobacco smoke when they are at work, while taking account of the needs of those who cannot or will not stop smoking.

Smoke-free NMAs and meetings
Among the medical associations which have made their premises smoke-free are those in Georgia, the Netherlands, Slovakia, Switzerland, and the United Kingdom. Among those which ban smoking at meetings are the NMAs in Germany and Malta.

Staff non-smoking policy
The introduction of a non-smoking policy for staff working for the NMA should be approached in the same way as is recommended for any workplace. The basic procedures are outlined below, and a more detailed guide is set out in Appendix 1.

Reference should also be made to the section on smoking in public places in Chapter 11, which highlights the special considerations affecting workplace smoking restrictions.

Use the medical press

To any NMA that already has a good working relationship with its country's medical press, using such links to convey a non-smoking message to a wider audience will be a natural extension of routine practice.

News stories and features about tobacco generated by the NMA will have numerous advantages to editors and journalists on medical publications, and other medical writers:

- They have medical authority
- They can always be made topical—there are always "pegs", or opportunities, on which to "hang" tobacco stories, especially with careful planning
- They have a serious underlying theme: the prevention of some of the major diseases afflicting modern society
- The availability of well-qualified experts—doctors—to interview and quote.
- Relevance to children (a great incentive to journalists): protection of children is a powerful motivation for tobacco control.

And where the tobacco industry is concerned (which can be in virtually any story on tobacco), there is the classic component of good versus evil, represented by health versus greed, and truth versus lies.

Keeping close to the press on tobacco

Every NMA will have its own way of liaising with the medical press. Frequent contact with medical journalists on tobacco issues will ensure that a core group of competent journalists is kept well informed about tobacco, which, as indicated elsewhere, is a more complex subject than many of them may at first appreciate.

Leading to closer press relations?

NMAs seeking a closer rapport with the medical press may find that the adoption of a major, ongoing campaign on tobacco presents an ideal opportunity for developing such a relationship.

The medical press may be more accustomed to dealing with the NMA on questions related to doctors' remuneration, the allocation of scarce health care resources or other, more traditional subjects. The campaign on tobacco may be presented in ways that offer a wider spectrum of interest to journalists, involving more contacts with leading members of the NMA.

All good journalists will welcome a ready and reliable source of information, explanation, and comment on tobacco-related stories, and will specially value assistance in analysing and responding to tobacco industry statements. They will therefore tend to approach the NMA more often, and undertake more thorough coverage of tobacco. They may even be encouraged, through this new working relationship, to cover more non-tobacco subjects of interest to the NMA, to mutual benefit.

Don't forget the NMA's own journals!

In addition to independently published journals, medical associations' own journals will be an obvious medium of communication with members about smoking. Medical associations which report regular coverage of smoking in their own journals include those of Israel, the Netherlands, and Slovakia.

It is especially important to ensure that journalists are briefed about misrepresentation by the tobacco industry of the scientific facts, its attempts to change the agenda, and the various other tricks that tobacco industry spokesmen will attempt.

Briefing doctors about smoking cessation

It is important that doctors are well informed about the latest evidence on smoking cessation techniques and effectiveness.

Whatever stage they may have reached in their personal education about smoking, all doctors will benefit from knowing what they can do to:

- Help those who want to stop smoking
- Encourage all smokers to try to quit.

Current practice

Most countries have a wide spectrum of current practice by clinicians. There are doctors who:

- Routinely monitor patients' smoking
- Use every opportunity to help and encourage them to quit.

Often these doctors have never received any formal training in cessation. At the other end of the spectrum, there are doctors who:

- Never discuss smoking with patients
- May be smokers themselves
- May be inhibited by their own smoking from trying to help their patients.

Caution: not too technical!

There is a fine balance between raising doctors' knowledge about smoking cessation, and making it appear unnecessarily technical. Doctors should not receive the impression that they cannot help their patients without specialist training.

Short training modules

A basic training module on cessation might consist of two 45-minute sessions:

- A review of cessation techniques and devices, and their proven effectiveness
- How doctors should monitor and counsel their smoking patients, to help them to quit.

A small trainers' panel of doctors could be assembled from those who are most knowledgeable and experienced in cessation, any of whom can deliver these modules. A collection of illustrations (35 mm slides, videotapes) can be assembled, for use in sessions.

These modules can be offered for inclusion in seminars on numerous topics which will be attended by appropriate specialists. For example, they could be given within meetings and seminars on heart disease, cancer, and chest disease, or as part of continuing education courses for specialists in these areas, and for general practitioners.

Training is desirable, but not essential

Cessation information and skills can be imparted to doctors in numerous ways, and the NMA tobacco group (which may usefully have a specialist cessation subcommittee) will want to consider:

- Medical publications—ensuring that they regularly cover cessation methods
- Training courses—may be especially useful for training a core team of experts, including the NMA cessation subcommittee

- Developing brief training modules for use within a wide range of seminars, with key speakers to teach them.

Support doctors in cessation activities

There are two issues here:

- Helping doctors who smoke to quit
- Encouraging all doctors to help their patients to stop smoking.

The second topic has been dealt with in Chapter 6, and so this section deals solely with encouraging doctors themselves to quit smoking.

Helping doctors who smoke to quit

First, it should be emphasised that, when dealing with smokers in general, and smoking doctors in particular, there is a risk of failing to achieve maximum effectiveness if the wrong tone is adopted.

What is the wrong tone in this context?

As many smokers may be defensive about their habit, they may tend to perceive any mention of quitting as critical, bossy, patronising, lacking in understanding of their plight, and in many other negative ways, and so they dismiss its message. To avoid seeming to come across in these terms, it is important to keep the message as objective as possible. It must avoid any judgemental tone, while making it clear that quitting is an urgent priority. It is also important to understand the denial process that can cause this reaction, to minimise the chances of triggering it.

Smokers' denial

The more smokers hear about the dangers of smoking, the more a part of their minds will acknowledge that they ought to quit. For doctors, with their superior knowledge of health issues, this part of the mind may have a particularly strong voice. Common sense demands an answer to the obvious question: *Why, if they know all this, do they continue to smoke?*

If smokers fail to acknowledge dependency on smoking, the only plausible explanation to the outside world for continuing to smoke is that the problem is not nearly so great as people say.

This does not stand up to serious examination, so smokers may try to change the agenda of debate. One response is to counterattack with charges that their freedom is being infringed, and that they are being victimised. They may adopt an aggressive resistance to any mention of their own smoking. In effect, they are in denial of their problem, including the problem of being not only a smoker, but a doctor who smokes, and as such, a bad example to others.

Dependent smokers who do not admit their dependency may fear the implicit admission that they are not in full control of their lives. This is threatening and inconsistent with their self-image, especially for doctors, who are responsible for the health and even the lives of others.

Acknowledging the power of addiction, or at least admitting the magnitude of the tobacco problem, may be sufficient to tip the balance of a smoker's feelings about their own tobacco habit. They will then be able to discuss the issue of smoking more objectively, as it affects themselves and the rest of the world.

Such smokers, who are basically unhappy about continuing to smoke, are known as "dissonant" smokers. As outlined in Chapter 6, passing into this state may be a necessary step on the way to cessation.

Ideas for action

The various practical steps which the NMA's tobacco group will take to support doctors in smoking cessation will depend on its review of what is most appropriate, but might include confronting the issue directly by arranging a series of meetings or counselling sessions in various locations, to offer sympathetic and well informed cessation help for those who smoke.

Medical press

- Reporting the results of a survey of doctors' smoking habits can lead naturally to information about the methods and benefits of doctors' quitting
- Regular coverage of other tobacco topics can be used to re-visit the issue of doctors' smoking, reinforcing the messages about doctors quitting
- Competitions may be held by medical publications, or by regional NMA branches, to identify the most successful ideas for encouraging doctors' cessation.

Review NMA investment portfolio

Many NMAs own or manage investments, either directly or as part of pension schemes for their members and staff. It is common to find tobacco company shares held in general investment portfolios, and if this is publicised (which may happen without warning), it can cause embarrassment.

Two of Sweden's largest insurance companies sold off their entire shareholdings in the tobacco company Swedish Match, after several anti-tobacco organisations focused attention on the ethical problems of such ownership. Here a member of Doctors Against Tobacco distributes an "alternative" annual report to Swedish Match shareholders in Stockholm, Sweden, in March 1997. From *Tobacco control—Swedish style*, by kind permission of the National Institute of Public Health, Stockholm, Sweden. Photo credit: Anders Kallersand.

Polish appeal

The Polish Medical Association reports that it appealed to all its members to give up smoking, an appeal repeated every year in the medical diary. The appeal ended with this stirring statement:

"We believe that our re-born free country can be gradually relieved from the social curse of nicotine addiction, and the Polish doctors as first in Europe will give the example of reason, strong will and patriotic attitude."

"*Floreat res medica!*"

("Long live medical matters!")

NMAs will want to review their investments and sell any tobacco holdings, and encourage other health organisations to do the same. It is clearly inappropriate for any organisation concerned about health to profit from tobacco; and conversely, publicising that it is getting rid of tobacco shares can assist the process of marginalising tobacco within society.

If regulations govern investments, stipulating that only earning potential should govern investment policy (as may be the case with pension funds), the NMA may want to consider changing the rules. Alternatively, it may decide to set up alternative funds free of tobacco.

Reference

Fowler G. In Bollijer CT, Fagerström K, eds. The tobacco epidemic. *Prog Respir Res* 1997;**28**:169.

10 Tobacco control: action for medical associations

This chapter describes how doctors, working through their national medical associations, can take the tobacco campaign outside the medical profession. It looks at the interaction between doctors and other sectors of society—in other words, inter-sectoral collaboration.

In this chapter

Formulate a tobacco action programme

As noted in the previous chapter, the most important requirement is for the NMA to have a special tobacco group to help to formulate and carry out its programme. This chapter assumes that such a group has been set up.

The NMA and national policy

In planning the NMA's activities, the principal aspects of national tobacco control policy should be kept in mind, to see how doctors can best fit into this strategy. Reference should therefore be made to the next chapter, on tobacco control policy.

Is there a national policy?

The NMA's initial priorities will be influenced by whether or not there is an existing national tobacco control policy.

If there is a national tobacco policy, either adopted by the government, or agreed by the leading medical and health organisations, the NMA's work will need to be in line with one or more items of the policy. This work, as outlined in the sections below, will be coordinated closely with other health organisations, especially the members of a coalition on tobacco.

If there is no national tobacco policy, an important first opportunity for the NMA in its work at national level is to draft one, and then circulate it widely, getting as many other organisations as possible to join the NMA in calling for it to be adopted by the government.

Preparing for battle

It is important that the leadership of the medical association is fully aware at the outset that it is embarking on a long and bloody war, which will involve some tough battles against those with vested interests in tobacco. But as in all wars, there are responsibilities and opportunities which bring out the best qualities in people with justice on their side, uniting them in a common purpose.

First priorities

There will be aspects of a national tobacco control policy that the NMA can begin to carry out itself, such as ongoing public information work, and—depending on resources—some of the public education work.

Otherwise, the NMA's first priorities will be to:

- Develop a model policy, if none exists
- Get maximum support among all organisations and individuals likely to be able to influence politicians
- Plan and coordinate a campaign to lobby for its implementation
- Monitor each stage of this process, and coordinate a strategy for keeping to plan
- To organise, or at least press for, a baseline report to be prepared, where reliable, up-to-date information on the country's tobacco situation is limited.

A big and complex subject …

It is important for NMA leaders to be aware of the complexity of tobacco control, which is why it is advisable to appoint various specialist members to the tobacco group.

It is equally important for the NMA to appreciate how long it can take to achieve measurable progress in national tobacco control. This is not an activity for those who get disheartened by lack of immediate results ….

Publication of a baseline report can be an important launching pad for a campaign for effective tobacco control policy, and the subject is dealt with on page 38.

Vested interests
National tobacco control campaigning not only brings the NMA head to head with the government, but also places it against powerful commercial forces. The international tobacco companies will lead the fight against any effective measures, but they will be supported, at least in the early days, by others with a vested interest in keeping minimum restrictions on tobacco. These include companies engaged in advertising, newspaper and magazine publishing, broadcasting (if tobacco advertising is still permitted on radio or television), the tobacco retail, wholesale and distribution trades, and tobacco workers.

In addition, among the most powerful allies of tobacco are sports and arts bodies which have succumbed to the temptation of tobacco sponsorship, and which find themselves sufficiently addicted to become apologists for its cause.

Working with other health organisations, including professional bodies

The process of developing a common position with other organisations on a model tobacco control policy may bring benefits far wider than creating a strong anti-tobacco lobby. Contacts made, trust earned, and the collaborative division of tasks and sharing of resources can lead to better inter-sectoral collaboration on a wide range of health issues.

A coalition on tobacco
The best way to collaborate with other professionals is through the structure of a coalition—any loose grouping of organisations that support the common goals embodied in a model tobacco control policy. By regular meetings, information sharing and joint activities, the maximum energy and resources can be brought behind the campaign.

If no coalition exists, the NMA is an obvious organisation to start one. It might approach:

- Other medical organisations, especially those representing doctors with clinical or research experience of tobacco disease
- Dentists
- Nursing and paramedical bodies
- Pharmacists
- Cancer, heart, and lung disease leagues
- Health promotion and education bodies.

At some stage, the NMA should consider widening the coalition to include representatives of other bodies which are not primarily concerned with health, but which support effective action on tobacco. These may include:

- Educational bodies
- Children's welfare groups
- Women's organisations
- Consumer groups
- Sports and cultural bodies
- Religious leaders and groups
- Labour unions.

According to the response of these organisations, the NMA may wish to invite them to nominate representatives to a meeting, to set up a coordinating committee to ensure the most efficient collaboration on tobacco control.

A labour union position on tobacco
Although tobacco workers' unions may at first succeed in delaying a large-scale show of support for health policy against tobacco, in due course it is likely that their position will change.

Their members, if sufficiently informed, will be able to see that their interests are not the same as those of their employers; and that the employers do not have the tobacco workers' interests at heart: far more jobs tend to be lost through ever-increasing mechanisation, than from a decline in tobacco sales.

Working with the media

Reference should be made to the section in the preceding chapter about working with the medical press (pages 31–32). Most of the same principles apply when working with the general press on national tobacco control issues.

List and train press spokespersons
Of special importance to non-medical journalists will be ready access to doctors and others who can provide expert comment and explanations on tobacco issues. The NMA should compile a list of members who have volunteered to be contacted for this purpose, and who are tobacco control experts.

The NMA should also consider running short media training courses for such members, especially to help them to respond to tobacco industry arguments. Media training is dealt with in Chapter 8.

Coordination
Staff and members of the NMA who have contact with journalists should ensure that their work is not carried out in isolation, to avoid duplication of effort and embarrassment resulting from different lines of argument. Larger NMAs will probably have a press officer, or a public affairs unit, to coordinate press and media work.

Journalists: easy to contact
Doctors and others who are not experienced with press work may not at first realise that most journalists, even the best known and most highly respected, tend to be surprisingly accessible and easy to contact, usually much more so than people of equivalent standing in medicine, or in other professions.

Working with politicians

The basic principles of working with national politicians are very similar to those for individual doctors working with their local politicians, as set out in a previous chapter. That section (pages 22–23) offers hints about how to make politicians feel it is to their advantage to accept invitations to meetings and other events which focus on tobacco control issues.

The main differences in working with politicians at the national, rather than local level, will be:
- The scale of the lobbying operation
- The need to monitor and review the different approaches and policies of all main political parties.

Monitoring

This should include recording how individual politicians tend to speak and vote on health issues. It will be particularly important to note which ones put health before commercial interests, and which seem to take sides with anti-health interests, especially tobacco.

Lobbying

Larger NMAs may already have parliamentary lobbying functions, with staff who have developed good working relationships with politicians concerned about health issues. If such expertise is not available, it may be possible to hire the services of various consultants, although it will probably be a better long-term use of the NMA's resources to have this function carried out by its own personnel.

Alternatively, another organisation within the coalition on tobacco which may be strong in this area—perhaps a dedicated tobacco control organisation (see below)—may take the lead in this work.

Ongoing lobbying activities should include:
- Regular meetings with friendly politicians
- Making submissions to politicians appointed to examine health issues
- Examining the parliamentary diary to anticipate any opportunities for raising tobacco-related issues
- Writing and distributing briefings to key politicians, to help them make the best use of their opportunities to further the case of tobacco control
- Meetings with the health ministry
- Meetings held during political party conferences, offering contact with the party's key health experts
- Briefing political journalists about current news stories related to political action (or lack of it) on tobacco.

Lobbying and the European Union advertisement ban

Lobbying by medical associations was a major element in helping to present members of the European Parliament with the health arguments for adopting the EU directive on (banning) tobacco advertising, a fiercely fought but ultimately successful battle against massive tobacco industry lobbying efforts. Medical associations in many European countries regularly lobby their governments and politicians about tobacco. Those reporting such activity include Armenia, Norway, Poland, Slovakia and the United Kingdom.

Campaigning for smoke-free health care facilities

This is likely to be a major strand of the NMA's early contributions to overall tobacco control policy.

It is likely that the NMA will already have active members—chest physicians, cardiologists, as well as public health doctors and others—who have taken a strong stand over many years at their place of work. If so, they should be invited to join the tobacco group, or to lead a subgroup on this topic.

There are many reasons for campaigning for smoke-free health care facilities:
- There is the strongest case for making health premises smoke-free
- They are places over which doctors usually have the most influence
- Doctors have a responsibility to put their own house in order, for the protection of patients and staff, and to set an example to others.

This is a specialised area with its own research literature and a wealth of experience around the world. In particular, NMAs in other countries will be able to share their experience.

Overall objectives

As with policy affecting smoking in any public places, the aim should be to make non-smoking the normal practice in health premises, so that non-smokers need never be exposed, with smoking areas permitted only in certain circumstances, and where non-smokers need never be exposed. The general principles are outlined in the next chapter on pages 47–48.

Lithuania: hospital's campaign

In Kaunas Academic Clinic, one of the country's largest hospitals, a tobacco-free hospital project is aiming to implement a rational tobacco control policy; to reduce smoking levels among doctors and patients, encouraging both groups to quit; and to prevent students from starting to smoke.

Influencing the content of medical education, and motivating medical students

This is an obvious area where the NMA can use the authority and influence of its members to make important changes.
- A list of medical schools should be drawn up, existing contacts at the schools used and new ones forged.
- A conference on the education of medical students about tobacco is an obvious option to be explored by the NMA tobacco group. Further details of this important topic are to be found in Chapter 8.
- Set up a dedicated tobacco control body for public information work

As tobacco control campaigning is a long-term activity in which special skills are an advantage, it is well worth considering setting up a special organisation. It can undertake the advocacy work outlined under the section dealing with public information in the next chapter (pages 45–46).

There are obvious advantages to having a special tobacco control advocacy body:
- Staff and volunteers of such an organisation will quickly develop expertise, and acquire detailed information

- NMA staff are likely to have other responsibilities, and so less time for intensive commitment
- Specialists will be able to keep abreast of the latest developments more easily, including international news, by a more intensive process of monitoring press and political news, and contact with colleagues in other countries (through the GLOBALink electronic communications system—see Appendix 3)
- Being dedicated only to tobacco control, and not competing with other health agencies to raise funds, it will not be perceived as having the conflicts of interest which can sometimes restrict networking and inter-sectoral cooperation between potential rivals.

Funding will be an important issue to settle at the outset. The NMA and other groups committed to tobacco control may have to invest time in persuading grant-making bodies such as cancer, heart, and chest disease societies that funds applied to tobacco control are a most important part of preventive work.

It may therefore take a matter of months, or even years to establish a common view that a dedicated tobacco control advocacy body is required to lead the public information campaign.

Perhaps the best model for such an organisation is one founded by the NMA, but representing at board level a wider range of interests. In effect, the board should mirror the wider tobacco control group, or coalition, described earlier.

Baseline report on tobacco

A baseline national report on tobacco presents a detailed review of the country's tobacco problem, together with priorities for dealing with it. If no such document exists, then the NMA should consider commissioning one, or pressing the government to commission it.

As it is based on scientific measurement of the problem, such a report will command the attention of other health groups, in addition to that of politicians and the press.

It can therefore be a useful tool not only for getting tobacco control on the agenda for discussion at the highest levels, but also for forging closer relations with other medical and health groups, which may be persuaded to join a coalition and campaign for effective action.

A baseline report should describe:

- The history of tobacco use
- Current and likely future patterns of consumption
- Patterns and projections of diseases caused by tobacco
- Recommendations for action to try to prevent as much as possible of this unnecessary burden of human suffering, health care and other costs.

Wherever possible the report should receive the backing of all the country's prestigious medical bodies. It should then be presented to the minister of health and to other national leaders and politicians with the request that legislation be introduced to implement the recommended tobacco control measures.

A baseline report should include:

- *Figures for the prevalence of tobacco use*, especially among influential groups such as members of various professions, including doctors, as well as women, and young people. Surveys of some of these groups can be carried out by students under the supervision of a competent scientist, such as a public health doctor or epidemiologist, who can supply guidelines
- *A survey of tobacco-related diseases in the country*. If reliable national statistics are not available, it may only be possible to use hospital discharge records, together with the experience of older doctors who have noted changes in the prevalence of lung cancer and coronary heart disease in their patients
- *Forecasts of the future incidence of diseases caused by tobacco use*, taking into account consumption trends. Those who become cigarette smokers in their teens face a one in four risk of premature death in middle age (before 65) as a result. As most men, including key professionals, still smoke in some European countries, this can lead to the loss of many valuable members of society
- *A review of the experience of other countries*—this is to be found from many sources, and international and national organisations can be contacted for information
- *A description of the operations of the tobacco industry*, especially the transnational tobacco companies, the brands they market, and the ways in which they promote them. This should include examples of tobacco promotion, especially that which seems to be directed at children and teenagers, and known examples of tobacco industry activities to influence politicians.
- *A brief economic assessment of tobacco*. Fuller studies may be made later of the economic consequences of tobacco, including, where appropriate, growing tobacco, which often may be very different from that which is commonly perceived.

The NMA's tobacco group will want to give careful thought to how the baseline report may be used, especially at the time of publication. For example, it may wish to sponsor a meeting to involve national leaders, preferably co-sponsored by the ministry of health. Plenty of time should be allowed to brief journalists in advance, and to agree with friendly politicians a course of action to ensure that the report is kept in the forefront of public and political debate.

Regular surveys and evaluation

An essential part of tobacco control policy is to carry out surveys at regular intervals to monitor progress and measure public knowledge and attitudes about smoking, so that each item of tobacco control policy may be evaluated and adjusted if necessary.

If the government embraces tobacco control seriously, then this function will be part of the measures it adopts, and the work will be commissioned by the ministry of health, or by some other appropriate body acting on behalf of the ministry.

However, if the government's adoption of tobacco control is less than total, it may fall to other organisations to try to ensure that this requirement is fulfilled. In such a situation, the NMA may decide to take the lead. It may either commission or undertake such work itself, or press others to do so.

On the assumption that the NMA may at least find itself being the catalyst for surveys and evaluation work, these topics are examined in more detail:

- Ongoing surveys on *tobacco-use prevalence, mortality, and morbidity* are necessary to measure the scope of the tobacco problem regularly, to illustrate the necessity of preventive measures and to evaluate the effectiveness of all tobacco control measures continuously. The use of WHO criteria and guidelines for prevalence surveys is helpful, as the data can then be assessed internationally
- Surveys of *public attitudes* to smoking are particularly important, so that preventive measures and health education address the beliefs of the general population. Such surveys can demonstrate to the government the level of public support for control measures—and this often turns out to be much greater than the government previously estimated.
- Surveys on the *economic impact of tobacco* are also important, to show that tobacco does not simply benefit the economy by taxation or export revenue, but that its use also results in various losses and costs. These include costs of medical and health care, lost productivity, social welfare costs from premature death and disability, fires, refuse collection, and the use of land that could be used to grow food and other cash crops. In most countries that grow tobacco, the large majority of the crop tends to be for internal consumption, which therefore raises questions about its economic contribution compared with alternative crops, quite apart from the increasing costs to the health service caused by the diseases which result from its consumption.
- Evaluation of the *success* of each anti-smoking measure is also important, to concentrate in the future on the most effective measures. This includes analysing the effect on the tobacco industry of any proposed or actual piece of anti-smoking policy. Relative effectiveness is usually indicated by the level of resistance or attempted sabotage of each measure by the tobacco companies.

In the context of the last point, it is appropriate to bear in mind two important rules of tobacco control, set out elsewhere in this book:

- If each aspect of a government's anti-tobacco policy is not fiercely resisted by the tobacco industry, it should be examined carefully to see why not—it may be ineffective or irrelevant
- If the tobacco industry welcomes or encourages measures, or tries to divert attention towards them, such as "product modification", or health education in schools, then the government should take heed that these measures, at least in their proposed form, may prove ineffective to reduce tobacco consumption.

11 Tobacco control policy

This chapter describes the key components of a national tobacco control policy. Reference should also be made to the World Health Organization's *Third action plan for a tobacco-free Europe 1997–2001*.[1]

In this chapter

Experts agree: for many years experts have concurred that effective tobacco control requires a comprehensive tobacco control policy, backed by tough, well monitored and strictly enforced national legislation.

Legislation, not self-regulation, is essential. It should cover the following topics:

- Banning all tobacco promotion
- Raising prices through taxation
- Public education and information programmes
- Strong, prominent health warnings
- Non-smoking as the norm in public places
- Banning tobacco sales to children
- Reducing toxicity of tobacco smoke
- Support for smoking cessation
- Phasing out tobacco growing and withdrawing any subsidies
- Considering legal remedies
- Regular monitoring and evaluation

Experts agree on policy

Among those authorities which have addressed the tobacco problem, mostly over many years, and recommended legislation similar to that summarised in this book are:

- The World Health Organization
- The International Union Against Cancer
- The United States Surgeon General
- The European Council of Health Ministers
- European Medical Associations for Action on Smoking and Health (EMASH)
- European Forum of Medical Associations
- World Medical Association

Countless others at international, national, and regional level have produced reports that have added to the body of knowledge about the health damage caused by tobacco, and supported the basic recommendations for dealing with it.

The need for comprehensive legislation

For more than a quarter of a century, distinguished experts and organisations around the world have examined the problems of tobacco use, and have recommended what should be done to prevent the disease, disability, and premature death that it causes.

There has been broad agreement for many years as to how to tackle the tobacco problem. Experts recommend a comprehensive policy: it must cover everything that is to be regulated; and it must be backed by tough, well monitored, and strictly enforced legislation.

Warning: results take time

It cannot be over-emphasised that tobacco control takes time, requires continuous monitoring and evaluation, and may need improvements and changes as appropriate. It is important that politicians and health advocates alike accept this, so as not to have unrealistic expectations, and to commit themselves to a continuing programme of work.

The principal measures that have been consistently recommended by such organisations, plus the consideration of legal redress against the tobacco industry, which is a more recent concept, are shown in the summary above.

In addition, two basic types of research related to the overall tobacco control policy should be carried out, especially in countries that have not yet taken much action:

- A "baseline report" should be prepared
- Surveys should be carried out regularly to monitor progress and measure public knowledge and attitudes about smoking, so that each item of tobacco control policy may be evaluated and adjusted if necessary.

The role of NMAs in stimulating these types of research was addressed in the previous chapter.

One further issue should be also be noted here: unlike, say, most epidemics of infectious disease, or public health problems caused by war or natural calamities, tobacco-induced disease has a crucial, extra dimension—one of the world's largest and most powerful industries is directly opposed to almost all the measures listed above.

Effective policy means fewer sales

Once it is appreciated that there is no such thing as a safe cigarette, a simple fact emerges:

> The success of tobacco control policy means the failure of tobacco companies' sales.

This essential truth must be acknowledged at the outset of any tobacco control programme. It means that effective policy will be strenuously resisted, by companies whose internal documents, released in court proceedings in the United States, show that they will stop at little to achieve their goals. Conversely, lack of serious resistance by the tobacco industry to new anti-tobacco measures suggests that the measures are not going to be effective.

"Cabinet table, not operating table"

"The solution to many of today's medical problems will not be found in the research departments of our hospitals, but in Parliament. For the prospective patient, the answer may not be incision at the operating table, but prevention by decision at the cabinet table."—Sir George Young, a British health minister who understood the politics of tobacco.

Deciding to tackle disease caused by tobacco means directly confronting the interests of the tobacco industry. Some NMA members may at first feel uncomfortable about this: they may say that the work is too "political".

Although not necessarily related to any one political party, tobacco control is indeed very political. If you are involved in the prevention of tobacco-induced disease, you are in politics. But there can be few more rewarding vocations in public health than effectively addressing the largest preventable cause of disease. Not only will many NMA members, when exposed to the details of the problem, be willing to join the fight, but many other organisations and individuals will, too. This is a fight against injustice, and as in all conflicts, it can bring out the best qualities in those who are moved to join it.

The NMA has a vital role in ensuring that politicians take effective action.

Legislation, not self-regulation

Before considering each item of a model tobacco control policy in detail, it is important to examine why comprehensive legislation, rather than self-regulation and other weak or partial measures, is so important as the means of implementing the policy.

Legislation will be effective only if it is:

- Comprehensive
- Closely monitored
- Strictly enforced.

The evidence that tobacco control policy cannot achieve maximum effectiveness without legislation becomes more abundant every year. The transnational tobacco companies, faced by increasing opposition from health campaigns, are becoming more aggressive, and more experienced at getting round weak regulations. This is especially true in those countries of Europe without comprehensive legislation.

"We advise self-regulation"—Tobacco industry

Tobacco companies always try to persuade governments that enforcement of tobacco policy by means of self-regulation, or "voluntary agreement", will be better than legislation. This is because they know that this system has far less effect on their sales. They will claim that experience in countries which implement tobacco policy by self-regulation shows the system is "very successful" and "works well". They can even quote statements to this effect from weak and ineffective health ministers in such countries, which, unfortunately, can sound convincing to other governments. Self-regulation works well for tobacco sales, but not for health.

What is self-regulation?

Self-regulation of tobacco control policy involves the following situation:

- The government and the tobacco companies agree a set of regulations, usually covering ways in which cigarettes may be advertised, and what health warnings they should carry
- The companies then agree to operate within these regulations
- The government promises not to introduce more stringent controls or legislation, and to ensure that any such moves (for example, by individual politicians) are defeated.

The truth is that self-regulation is indeed "very successful" and "works well"—for the tobacco companies. However, it is far from effective from the point of view of improving health. A system of self-regulation or "voluntary agreements" on tobacco advertising merely leads to increasingly frequent and sophisticated methods of getting round the regulations, and of defeating the government's intentions.

The defects of self-regulation

The main shortcomings of self-regulation of tobacco policy are as follows:

- It is not comprehensive, but selective in nature: many significant types of tobacco promotion tend to be excluded from the regulations
- Several different departments of government tend to be involved, often pulling in opposite directions
- The voluntary nature of the system means tobacco companies have little to lose by breaching the agreement, and nothing to lose by refusing to agree to more stringent measures, provided there is no real threat of legislation
- The many meetings between ministers and officials with representatives of the tobacco, advertising, publishing, and retail industries, mean that negotiations for new regulations can take a matter of years; this gives plenty of time for tobacco companies to plan how to circumvent the restrictions that are being negotiated
- Being one of the parties to the self-regulation agreement, the health ministry is effectively neutralised
- A government that tries to control tobacco by a system of self-regulation is obliged to defend this method—to do otherwise would be to admit error or weakness. This delays reform, and is a bad example to other countries.

Striker turns referee

Although the ministry of health is the obvious source from which improvements in tobacco control are initiated and executed, a self-regulation system involving the government forces the ministry into the position of observer, or at best, a mediator in the contest between health on the one side and the tobacco industry on the other. It is like the best player in a soccer team being forced to leave his team, and become the referee.

Divide and conquer (the ministries)
In a classic self-regulation scheme, government ministries are effectively set against each other. For example, the ministry responsible for sport would like private industry to provide as much sponsorship as possible for sport; but tobacco sports sponsorship has precisely the opposite effect to what the health ministry is trying to achieve—it will be trying to ensure, among other things, that tobacco is not linked with the healthy and exciting qualities associated with sport. This link explains precisely why tobacco companies sponsor sport.

Tobacco control policy

Before each of the components of a model tobacco control policy (listed at the start of this chapter) is examined in detail, some general observations are relevant:

- There is increasing experience in Europe and further afield of comprehensive tobacco control legislation
- The actual legislation can be relatively simple—indeed, the more complex the wording, the more likely it is that the tobacco companies and their lawyers will find a way round it
- Model tobacco control acts have been drafted by international experts; obtainable from WHO, they may require changes to fit the requirements of each country's legal system
- The tobacco control community, at national and international level, will help NMAs and governments, with regard to campaigning for legislation, drafting it, or with its implementation
- The tobacco industry will almost certainly take legal action to challenge legislation. It has almost unlimited resources to do so, and nothing to lose. It is best that all those backing legislation realise this from the outset. It is the ultimate indication that their law will be effective.

Banning tobacco promotion

Of all the items in a comprehensive tobacco control policy, a ban of all forms of tobacco promotion is the one most fiercely contested by the tobacco industry.

This explodes the myth that the industry tries to create, that tobacco promotion has no effect on attracting new customers or in increasing sales, and only makes people switch brands. If this were really true (which internal industry documents make quite clear it is not), the companies would not spend so much money on promotion, but would instead lower prices, to get an advantage over their competitors.

Types of tobacco advertising

Tobacco is probably promoted in more ways than any other product, including:

- Direct press and poster advertising
- Television and radio advertising
- Sponsorship of sports and arts
- "Brand-stretching" advertisements for other products (see below)
- Commercial spots in cinemas
- Distribution of free samples
- Gift coupon schemes
- Point-of-sales advertisements
- Public relations activities
- A host of other direct and indirect advertising schemes.

Direct and indirect advertising

- Direct advertising means all forms that directly promote a brand of cigarettes or other tobacco goods
- Indirect advertising covers all other forms of promotion that are intended to advertise a tobacco brand, but which pretend to be something different; sponsorship and brand stretching are the two most common forms.

It's all tobacco advertising!

To tobacco companies, sponsorship is simply a form of advertising, as thousands of internal tobacco industry documents released though American litigation make clear. In the words of one tobacco industry executive: *"Sponsorship is a form of advertising which enables us to introduce glamour and excitement."*

Sponsorship is the method most commonly used to circumvent advertising bans. Apart from its obvious advertising advantages, it also buys:

- Silence and support from people and organisations who ought to be the natural allies of health, such as sports stars and the governing bodies of their sports
- Support from the general public, or rather, the public's protest if a sport dependent on tobacco money is threatened with losing it because of tobacco control legislation.

Health promotion funds are the solution

A solution to the problem of tobacco sponsorship has been pioneered in Australia, where a small, additional tax generates a large fund that not only pays for all state expenditure on medical research and health promotion, but also can offer alternative sponsorship to sports and arts bodies which previously received tobacco sponsorship.

Brand stretching

Tobacco companies try to get round advertising restrictions, even bans (where legislation is weak or vague), by means of "brand stretching". This is a technique for promoting cigarette brands by advertising other products using identical colours, logos, and typefaces as those used in cigarette advertisements. Common examples are Camel boots and Marlboro clothing.

This trick highlights the need for comprehensive legislation, allowing no exceptions to the ban, and for rigorous monitoring and enforcement. Tough legislation does work, as an increasing number of countries are finding.

Brand stretching is probably the fastest growing form of indirect tobacco advertising in Europe, especially in the EU countries, no doubt because of the tobacco companies' belief that trade law and international trade agreements will keep this avenue of promotion open even under a ban. At the time of writing, this was among the major concerns of health ministries in EU countries as they drafted national legislation to implement the EU advertising directive.

On no account must indirect tobacco advertising be allowed to circumvent an advertising ban.

Belgium: court dismissed industry plea
Tobacco companies received large fines for infringing advertising regulations in Belgium, by promoting cigarette brands via other products not directly associated with smoking. The court refused to accept the companies' plea that the regulations were unclear about indirect advertising, or that the companies were not aware of the consequences of indirect advertising. The fines reflected the number and duration of infringements and the fact that most were aimed at young people. Legislation works!

Exactly similar promotional activities were being practised by the same companies in other, nearby countries, where self-regulation failed to stop them even though they clearly violated government intentions.

Special aspects of tobacco advertising
In looking in more detail at this aspect of tobacco control policy, it is worth examining certain special characteristics of tobacco promotion:

- Image is everything: tobacco advertising contains virtually no useful consumer information
- It is almost exclusively used for associating cigarettes with positive images and associations
- Tobacco companies never voluntarily mention the unique and substantial risks involved in consuming their products
- Most brands and advertisements are targeted to a specific group—young women, for example, or younger men in lower socioeconomic groups.

Tough or feminine?
All cigarettes are intrinsically the same: they are tubes of paper with chopped, dried tobacco leaves inside. The fact that one brand of cigarettes is perceived as being associated with characteristics such as manliness, toughness, sportiness, and success, and another brand with feminity, chicness, fashionableness, slimness and "coolness", is entirely due to advertising.

Arguments against tobacco advertising

- Tobacco promotion helps recruit young people to smoking
- It maintains the social acceptability of tobacco use
- Health education cannot deliver its message effectively—especially to young people—against a wealth of images associating cigarettes with success, glamour, independence, sports, and other desirable, positive images
- Ethical reasons—no decent society should tolerate the deliberate association of positive images with a product that is addictive, always dangerous, and kills half of its long-term users, especially when children are the targets
- Tobacco advertising revenue restrains publications from reporting the dangers of tobacco adequately.

"I am a doctor. I believe in science and evidence. Let me state here today: tobacco is a killer. Tobacco should not be advertised, subsidized or glamorised."—Dr Gro Harlem Brundtland, director general, World Health Organization, World Health Assembly, Geneva, Switzerland, 13 May 1998.

The protection of children is the most persuasive argument to present to governments for a ban on tobacco promotion:

- There is evidence worldwide to show that children are influenced by tobacco advertisements
- Most smokers start their habit while they are children
- Countries that ban tobacco advertising tend to show a significant fall in the rates of children's smoking.

"If it's a legal product …"
The tobacco industry's favourite argument against a ban is that if products are sold legally, it should also be legal to advertise them.

This argument fails for several reasons:

- It is a historical accident that cigarettes and advertisements for them are legal—they had been sold for many years before their unique harmfulness became known
- There are common exceptions to the argument—in many countries, for example, certain pharmaceuticals and other toxic chemicals may not be advertised to the general public.

Help is at hand!
Fortunately, in all areas of tobacco control policy, there is now a wealth of experience and support available to help countries embarking on an advertising ban. Information about model laws, frequent methods of attempted circumvention, including details of typical tobacco company arguments, and the "experts" they send to fight their case, are readily available. In the first instance contact should be made with the organisations listed at the end of the book.

Raising prices through taxation

One of the essential items in a model tobacco control policy is the regular increase of the price of tobacco products by means of tax increases:

- Price is probably the single most powerful factor influencing short-term tobacco consumption
- Price has been shown to play an important role in determining how many young people start smoking.[2]

A model tobacco control policy should therefore include a regular (preferably annual) increase in tobacco tax to ensure that the real (adjusted for inflation) price of tobacco rises each year.

Tobacco tax increases should be regular. By Madhusudhana, by kind permission of the *Economic Times*, India.

Surprise the finance minister!
Tobacco tax rises are among the easiest policy gains to achieve—it is highly unusual for finance ministers to be pressed to increase tax.

There are many examples of finance ministers, when announcing a tobacco tax rise, explaining that they have acted at the request of medical experts (incidentally, this is useful extra publicity about the dangers of tobacco). It can help public acceptance of their decision.

Arguments for a tax rise

- It cuts consumption of a uniquely dangerous product
- It raises government revenue
- It is easy to implement: governments already tax tobacco, so there is no need to develop any new or complex system.

Experience in many countries has demonstrated that price rises are an extremely effective tool in reducing tobacco consumption. The precise effect will vary, but, on average, the "elasticity" is about –0.5, meaning that a price rise of 10% results in a fall in sales of 5%.

At the same time, government revenue will rise! A tax rise simultaneously reduces sales but increases revenue. In fact, if the government does not regularly increase tobacco tax, inflation will erode the value of its tax revenue, so in real terms it will earn less.

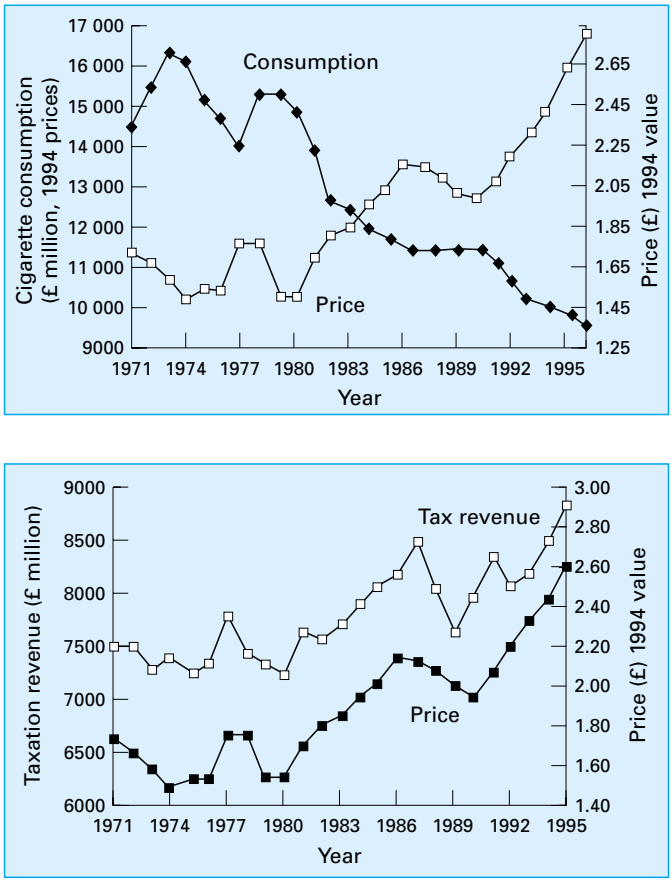
It should also be borne in mind that some of the proceeds of higher tobacco taxes can be used to fund other parts of the government's overall tobacco control effort.

An effective tax policy will include:

- Significant increases in the tax on tobacco. The price of tobacco should constantly rise in real terms, taking account of the effects of inflation and also of any growth in average earnings
- Tax increases should be regular. One solution is to provide for automatic increases which keep pace at least with increases in the consumer price index.
- In some countries tobacco has been taken out of the consumer price index, to counter politicians' fears that tax rises affect the rate of inflation though the cost-of-living index
- The structure of tobacco taxes should reinforce health policy objectives. This means having a high "specific" element (the fixed sum per pack) to prevent the industry from being able to market very cheap cigarettes
- The structure should minimize loopholes—for example, by taxing hand-rolled tobacco on the same basis as manufactured cigarettes, to avoid any incentive to switch rather than reduce consumption or stop smoking
- Effective anti-smuggling controls.

Arguments used against tax rises

"Tax rises increase smuggling"—Large tax differentials between nearby countries do tend to increase smuggling, but failing to take action for this reason is like not buying a better computer for a hospital for fear that it might get stolen. The answer is to work by every means possible to minimise smuggling—the most effective solution is for all countries in a region to harmonise tobacco tax levels. Increasing staffing of customs departments should also be regarded as a necessity, but it will cost a small fraction of the extra revenue earned from tax rises.



The relationship between the price of cigarettes and (top) consumption (1971–1996) and (bottom) tax revenue (1971–1996) in the United Kingdom. All variables are adjusted for inflation. Adapted from Townsend,[3] by kind permission of the publishers.

Not so innocent…
There has been growing evidence that tobacco companies are aware that some of their production goes to the black market, and that some deliberately collude with criminal activity, to increase the total sales of their brands. European Union governments are so convinced of this that in May 1998 the EU announced that member states would seek help from the United States, to try to stamp out the smuggling of American cigarettes into Europe. The EU cited allegations that the manufacturers routinely sold American cigarettes to traders and dealers, who resold them through channels set up to evade taxes.

"It will make tax revenue decline"— In fact, tobacco tax is very "inelastic" in economic terms, which means that even though tax rises cause a decline in consumption, the decline is not so large as to reduce overall tax revenue.

The smaller amount of tobacco sold after the rise, carrying the higher rate of tax, will earn more tax in total than the larger amount sold before the rise at the old, lower tax rate.

Even in countries with high tax rates, such as the United Kingdom, officials confirm that the "point of diminishing returns", when total tax revenue would fall after a tax rise, lies far in the future.

"Tax rises are socially regressive," as they hit the poorer members of society harder. In fact, the extra burden after a rise is borne more by the wealthier smokers, who can afford to continue smoking as before, than by the poorer smokers, who tend to reduce or stop their smoking.[2]

The solution is not to provide poor people with cheap tobacco—hardly a benefit—but to use some of the proceeds from higher taxes to compensate poor people with support to quit smoking. Failure to raise tobacco taxes out of concern for the welfare of the poor simply makes it easier for the industry to condemn another generation to addiction to tobacco.

"Tax rises will harm employment in tobacco factories or among farmers."—Low tobacco taxes are an ineffective form of industrial support: it is much more cost effective to raise tobacco taxes and then provide any necessary support for those whose livelihoods depend on tobacco. In the long term, far more jobs will be created elsewhere, as people spend their former tobacco money on other goods and services: tobacco is the least labour-generating of all industries.

"Tax makes governments dependent on tobacco tax revenues and hence reluctant to adopt health measures."—This is far from the truth. The governments with the highest tobacco taxes tend also to be those with the most stringent anti-tobacco laws. Moreover, the reduction in consumption that higher taxes can bring about makes it easier for other policies to be introduced—for example, on workplace smoking.

Public education and information

Definitions

Public education denotes research-led, pre-tested education programmes aimed at specific target groups, such as schoolchildren of various ages, young adults, or women smokers.

Public information work consists of producing and disseminating a continuous flow of accurate and topical tobacco control information, and quickly responding to any opportunity to inform the general public or special target groups (such as politicians), via the news media.

Public education and public information programmes often overlap; and both are essential components of a comprehensive tobacco control programme. They do not compete with each other, but rather they complement and reinforce one another. Each will now be examined in more detail.

Public education

This is a specialist area, and in most countries it will be carried out either directly by officials within the health ministry, or by state health promotion organisations. In some countries well established medical charities also run their own public education programmes.

Among the main objectives of public education programmes about tobacco are to:

- Change the behaviour of those who use tobacco
- Maintain the behaviour of non-users
- Establish the realistic view that tobacco is very dangerous to health
- Ensure the right of non-smokers to smoke-free air
- Change the cultural background of society in which tobacco use may be viewed as a normal activity.

Steps in a public education programme:

- Gathering baseline data of current tobacco practices and attitudes
- Defining the target group
- Analysing the problems to be tackled
- Designing materials and strategy for each target group
- Training those who will deliver the programme
- Pre-testing on small groups, and adjusting to correct any faults
- Delivering the main programme to the target group—for example, doctors actually handing a special leaflet to pregnant patients who smoke
- Conducting a thorough evaluation.

Maximum effectiveness of any tobacco education programme will be obtained with a plan for reinforcement once the programme has been completed.

Wasting precious resources

All health educators have horror stories of well intentioned health education programmes on tobacco (and on other topics), which have been continued even after being shown to be of little or no value; similarly, they know of massive expenditure on projects, such as leaflets, which have not been pre-tested.

The reason for such folly may be political—politicians often suffer from a short-term approach, keen to show voters that they have taken action, allocated resources to fix a problem, and so on; and there may be pride and prejudice among those who devised the programme, who feel such personal ownership that they are unable to admit that it is ineffective.

Direct involvement of appropriate NMA personnel, such as experienced research scientists, may help to avoid such errors.

Be realistic! It is important to accept at the outset that public education programmes cannot be expected to achieve unrealistic goals. In the commercial world (and experienced advertising executives are a great bonus to any group undertaking mass media public education), companies celebrate advertising campaigns that result in market swings of just a few percentage points, often with much larger and persistent expenditure than will usually be available to health campaigns.

How can health compete, when tobacco spends so much? One answer to this question is the allocation of regular advertising opportunities in public media, such as on state radio and television channels. Similarly, the government can build into licence agreements for private broadcasters, a minimum number of public service slots, and for some of these to be used to carry anti-tobacco spots.

Public information

Among the main objectives of public information programmes about tobacco are:

- Increasing public awareness of the health consequences of tobacco

- Encouraging adults to give up smoking and other tobacco use
- Influencing and informing young people
- Creating an atmosphere in which tobacco use is seen as unhealthy behaviour
- Establishing the rights of non-smokers to breath smoke-free air.

The characteristics of a public information programme:

- It is opportunist, in the best sense—it exploits any opportunity to use the news media to convey information to large numbers of people, including special target groups
- Those who operate it have a good understanding of the way the press and broadcasting organisations operate
- They maintain good relationships with journalists, to be readily accessible and able to supply information and comment
- Suitable experts are available to give interviews and assist journalists whenever necessary.

Such work may be undertaken routinely by the NMA, and may be part of the work of the press and public affairs staff, backed up by medical colleagues. In other situations, however, public information work on tobacco may best be undertaken by the sort of specialist tobacco control body described in the preceding chapter.

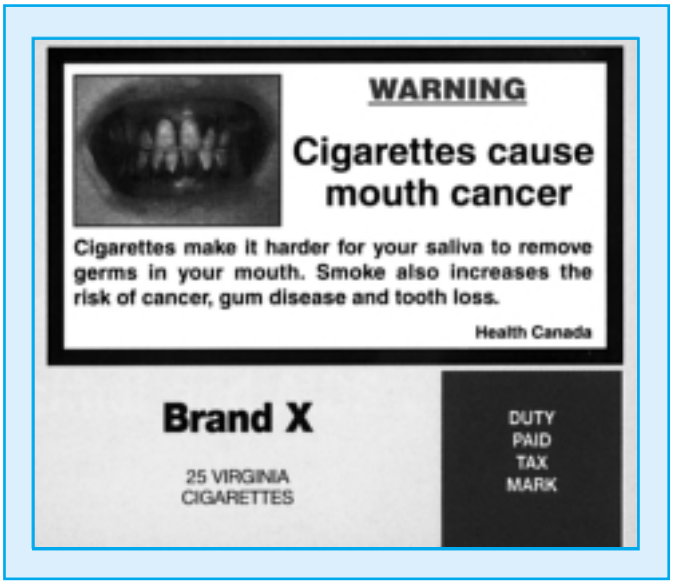
Typical public information activities include:

- Publicising specific policy objectives, to mobilise sympathetic public support for them—for example, for tobacco tax rises
- Analysing and responding to tobacco industry propaganda and activities
- Discussing, emphasising, and reinforcing the importance of anti-tobacco activities.

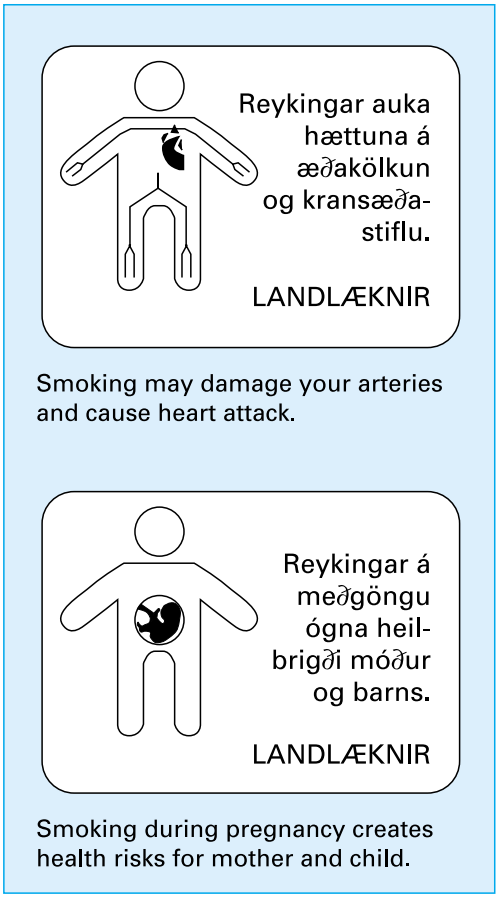
Of special interest to journalists may be:

- The medical and scientific case against tobacco
- Changes in tobacco consumption trends
- Tobacco use amongst exemplar groups, such as doctors, teachers, or athletes
- Ways of giving up tobacco
- Government action (or lack of it) against tobacco
- What schools are doing about tobacco
- The rights of non-smokers
- The special problems of women and tobacco
- Special non-smoking days or weeks—such as WHO's World No Tobacco Day.

Good examples which cover several of the areas above are the launch of the NMA's campaign against tobacco, and key points during the campaign, such as when a special report is published.



One of the striking new health warnings advocated by health groups in Canada, circulated for debate in 1999. The same designs are also being considered in Norway.



Examples of warning labels on cigarette packets in Iceland. From *Physicians on tobacco*, published by the Swedish Medical Association.

Health warnings

An essential item in a model tobacco control policy is the compulsory display of strong, effective health warnings on the packages in which cigarettes and other tobacco goods are sold to the public, and on all advertising as long as it is permitted.

An effective system of health warnings recognises the unique threat that tobacco poses to its consumers. This is a crucial part of the concept of informed consent, which will be found in virtually every country; it is worth remembering here that close cooperation with a consumer organisation, especially with experts in consumer law, will usually be an asset to any tobacco control campaign.

Health warnings also offer a cost effective health education programme. It is not sufficient simply to have a warning system in place—the key word is *effective*.

To be effective, warnings should:

- Contain clear, unambiguous messages about the dangers of tobacco use in simple and stark terms
- Warn not only of the risk, but the *relative size* of the risk—evidence suggests that while smokers may be generally aware of the risks, they often have little understanding about individual diseases, and many of them greatly underestimate the scale of the risks involved, especially in relation to other perceived risks in their daily lives
- Be illustrated by graphic pictures or symbols, where a significant proportion of smokers cannot read, or do not understand the language used in the health warnings
- Exclude attributions such as "ministry of health warning", as research shows that they make the message less effective.
- Apply to all tobacco products and all forms of packaging, including those displayed at the point of sale
- Be prominent, at the *top* of the front and back of the pack, covering a minimum of 25% of each
- Disclose all harmful constituents and additives, with a statement of their known health effects
- Contain a clear statement of the tar and nicotine ratings, with notes about their serious limitations (wherever possible, the measurements should be verified by an independent laboratory)
- Exclude misleading names and labelling: regulations should prohibit terms such as "light" or "ultra light"
- Require the manufacturers to rotate a series of warnings at any one time, say 10, so that over a few weeks, smokers see all of them.

The tobacco control legislation must specify the precise effect desired, as the tobacco industry always uses any loophole it can find to reduce the impact of health warnings.

The pack as health advertisement
An effective warning system will ensure that the tobacco pack becomes more effective at promoting the health message than it is at promoting a desirable image of tobacco use. It must display the health message as prominently as the manufacturers would like their design to promote the product.

Free, in-pack health promotion
Making manufacturers place longer health messages inside the packet is an innovative health promotion opportunity, targeted directly at tobacco users. Such inserts not only allow longer warnings, but also the use of graphics to bring home the dangers of tobacco use more clearly. This approach is strongly recommended.

Smoking in public places

The basic goal of tobacco control policy in this area is to protect non-smokers from other people's tobacco smoke while they are in public places, or on public transport.

This means making non-smoking the norm, with smoking areas specially provided where appropriate—the opposite of the situation in most European countries at present.

Non-smoking policies also have the advantage of cutting total consumption, as it has been shown that smokers do not compensate fully for cigarettes not smoked while they are in non-smoking areas.[4] In addition, this aspect of policy helps diminish the social acceptability of smoking, which is why it is so actively resisted by tobacco companies.

Arguments for restrictions

- The protection of non-smokers from the risk of serious disease
- The establishment of non-smoking as the norm, with special relevance to children.

A tobacco executive's view
After the world conference on tobacco and health in Stockholm in 1979, a tobacco industry observer commented on a speech by the then director general of the WHO, that it was: *"A confirmation of our own analysis that the social acceptability issue will be the central battleground on which our case in the long run will be lost or won".*

The case of the disappearing spittoon
The analogy of spitting is helpful when considering the process of change that must take place with smoking. In the 19th century, spitting was quite commonplace in many countries (no doubt partly due to air pollution in cities). It was specially catered for by spittoons (the equivalent of ashtrays in this analogy). As medical opinion evolved about the transmissibility of disease through spitting, and as people's living standards and social habits changed, it became socially unacceptable, and more than that, was outlawed in public places. "No spitting" signs were erected, and in time spitting so declined that the signs and spittoons were no longer needed: non-spitting had been established as the norm. People who want to spit are still free to do so, but do not spit in most public places, or on public transport.

Arguments against restrictions

"It is discrimination against people who choose to practise an innocent habit."—There are several fallacies to this favourite tobacco industry argument, but most relevant here is the fact that the evidence on the dangers of long-term exposure to passive smoking is now well established.

"People will be banned from public places."—This is obviously nonsense, as smokers will still be able to use all the facilities: the only change is that they will not be able to smoke during the time they use them, just as people who practise other harmful habits do not claim the freedom to endanger other people.

NMAs lead the way!
Medical associations can play a leading role in campaigns for smoking restrictions in public places, and there are many success stories. The concerted effort by many NMAs from the European Forum of Medical Associations was particularly effective in getting airlines to ban smoking on their flights; among those in Europe are NMAs in Denmark, Malta, the Netherlands, Norway, and Slovenia.

"Scientists are divided about the research showing that passive smoking is harmful."—The tobacco industry has constructed a deliberately fraudulent body of research on this issue. Among genuinely independent scientific authorities, there is no such division.

"Ventilation is the solution"—Even the best ventilation equipment is unable to eliminate all the toxins in tobacco smoke, as well as being expensive, and often inappropriate due to the layout of indoor spaces.

Why the workplace is a special case
The workplace poses special responsibilities, and special considerations, when framing a smoking ban or restrictions. Responsibilities derive from the fact that, unlike most public places, people tend to spend not the occasional half hour, but up to eight hours or more there every day; and unlike, for example, a bar or restaurant, which they are free to leave, or not to enter at all if it is smoky, there is usually no such choice for employees at work. The main issues of workplace smoking, and how to implement a good workplace smoking policy, are covered in Chapter 9 and Appendix 1.

Banning sales to children

In many countries, this is among the oldest areas of public policy on tobacco. The purpose is to try to prevent access by children to tobacco:

- Because they are specially prone to its harmful effects
- To try to stop them becoming regular tobacco users.

There are often defects in the theory and practice of bans on selling tobacco to children:

- They are often poorly enforced, as police and other authorities do not see them as a priority
- Children themselves, especially the most rebellious, may see the ban as an exciting challenge (a "forbidden fruit" image), and proof of smoking as a badge of adulthood.

A ban should:

- Make the offence of selling the goods entirely the burden of the person who does the selling, and not the child
- Be backed by heavy fines and possibly a system of licensing
- Involve monitoring and support from community and education bodies.

Further information can be obtained from numerous sources, including various European projects on children and tobacco.

Reducing toxicity of tobacco smoke

A model tobacco control policy should include the power to regulate the levels of the harmful constituents of tobacco smoke, including tar, carbon monoxide, and nicotine. The overall goal is to make smoking less dangerous for those who cannot or will not quit.

Important aspects of tobacco toxicity

- The harmfulness of smoking is related to the concentrations of toxic chemicals in the smoke. Reducing exposure to toxins can reduce the risk of various diseases caused by smoking
- Measurements commonly used by governments and tobacco companies are misleading, as they are based on laboratory methods which do not necessarily reflect the extent of smokers' exposure to the toxins
- Smokers tend to smoke low tar cigarettes more frequently or intensively, and obstruct ventilation holes—often unintentionally. Studies have shown that, when smoked under these conditions, tar yields may be 10 times higher than the official levels.[5]

The policy should:

- Be administered and monitored with strict government control: the tobacco industry must never be permitted to determine the way emission policy is implemented, or be actively involved except to comply with legally enforced standards set by the government.

Although debate continues about the health benefits of this area of tobacco control policy, it is recommended that if emission levels exceed EU recommendations, the government should:

- Order the progressive lowering of emission levels of all brands
- Set upper limits, excluding higher emission products from sale.

Toxin reduction policy should be firmly implemented and monitored by means of legislation, as part of a wider strategy to reduce smoking induced disease.

WHO and the UICC have suggested the goal of a market range of cigarettes between 5 and 15 mg of tar. The UICC recommends progressive eradication of high tar brands from the market, starting with all brands over 25 mg; then 20 mg; then 15 mg. The European Commission has called for all 12 member states to set an upper limit of 15 mg of tar per cigarette, which fell to 12 mg in 1995.

In the light of evidence about the relative dangers of individual toxins, some experts advocate a low tar, low carbon monoxide, but medium nicotine cigarette as the least dangerous product for those who continue to smoke. However, in October 1998, the American, Australian, and British Medical Associations jointly called for their countries' governments to make cigarettes less addictive by forcing manufacturers to reduce nicotine levels to zero or negligible levels in the next 10 years.

Warning: research fraud
The tobacco industry has abused this aspect of tobacco control policy to try to justify continued tobacco advertising, maintaining that to reduce average tar yields, new brands will have to be introduced and that advertising will be needed to make the public aware of them. This is untrue: changes can be made to existing brands simply by altering their yields.

Support for smoking cessation

Like every other item in a comprehensive tobacco control policy, support for smoking cessation is an important part of the whole package, and is inter-dependent on the other measures.

Some governments are not at first keen to promote support for smoking cessation within a tobacco control policy,

as they may (mistakenly) believe that this implies a net cost, whereas most other items of policy have no significant cost. In fact, if the government is following the right policy on taxation (see above), it is easy to allocate part of the additional revenue raised to provide the necessary resources. In short, there is no reason why supporting cessation need result in a net cost.

Equally important is for the government to be seen to be supporting the concept of cessation. If conditions favouring cessation include the decline in the social acceptability of smoking, and smokers' feeling supported in their efforts to quit, then making this a prominent part of the national policy on tobacco control is an important starting point.

The national tobacco control policy should therefore include support for cessation, and may give the health ministry certain powers and duties. These can include setting goals and standards for health care authorities with regard to cessation, and stating overall policy to encourage cessation and provide adequate help for smokers who want to quit.

Reference is made to the British smoking cessation guidelines for health professionals.[6] Smoking cessation is dealt with in detail in Chapter 6.

Agriculture

This is a specialist area where further information should be sought from national and international development agencies, and from health workers in countries which have addressed similar problems.

In summary, it is worth noting that the Food and Agricultural Organisation of the United Nations has addressed this issue, and is sympathetic to the need to encourage a move out of tobacco farming into harmless crops. The World Bank has also recognised this need, and many countries' individual aid policies also reflect a bias towards not promoting any aspect of tobacco production or manufacture, and encouraging and assisting countries to facilitate a shift away from any aspect of it.

Litigation

This subject, which is assuming increasingly great importance, is dealt with in more detail, including the doctors' role in litigation, in the next chapter. It is listed here, as it should be in any overall tobacco control policy, in recognition of the fact that what was once seen as an area which might yield public health benefits for a few countries, has now been shown to be a vital avenue to be explored by every country.

The subject is dealt with in more detail, from the perspective of doctors' role in litigation, in the next chapter.

References

1 World Health Organization. *Third action plan for a tobacco-free Europe 1997–2001*. Copenhagen, Denmark: WHO Regional Office for Europe, 1997.

2 Chaloupka FJ, Wechsler H. Price, tobacco control policies and smoking among young adults. *J Health Econ* 1997;**16**:359–73.

3 Townsend J. The role of tobacco taxation in tobacco control. In Abedian I, *et al*, eds. *The economics of tobacco control*. Cape Town, South Africa: University of Cape Town, 1998:89.

4 Borland R, *et al*. Effects of a workplace smoking ban on the consumption of cigarettes. *Am J Public Health* 1990;**80**:178–80.

5 National Cancer Institute. *The FTC cigarette test method for determining tar, nicotine, and carbon monoxide yields of US cigarettes: report of the NCI Expert Committee*. Bethesda, Maryland: National Institutes of Health, 1996. (NIH Publication No 96-4028.)

6 Raw M, *et al*. Smoking cessation guidelines for health professionals. *Thorax* 1998;**53**:suppl 5.

12 Doctors and tobacco litigation

In this chapter
- A relatively new tobacco control strategy is the use of litigation against the tobacco industry
- In many countries, tobacco uniquely evades consumer protection laws
- Litigation has developed primarily in the United States, but is being followed by cases in Europe and elsewhere
- Doctors have a role as witnesses, and NMAs are encouraging litigation
- Substantial amounts of internal industry documents have been released into the public domain
- Other forms of litigation have been tried, and more may arise in future
- There are dedicated tobacco control legal groups, whose experience and advice is available to those contemplating action.

Litigation: a new strategy

Although most aspects of tobacco control have been recommended and practised over several decades, a relatively new one is of growing importance: the use of litigation.

Until comparatively recently, the only major use of lawsuits in relation to tobacco control was by tobacco companies—mostly to challenge governments' attempts to control their promotional activities and to implement other aspects of tobacco control policy. The late 1990s, however, have seen dramatic results from years of work by lawyers and health groups, first and foremost in the United States, but latterly in other nations too, in attempts to use civil law against tobacco companies.

There is no doubt that this aspect of tobacco control will continue to increase in scope and importance, and NMAs will increasingly be asked to support it in various ways.

Tobacco is unique in law

One of the most striking achievements of the tobacco industry over many decades has been successfully evading the legal controls routinely applied in most countries to a wide range of other potentially dangerous consumer products, even though tobacco far outweighs all of them as a cause of ill health and premature death.

Foods, alcohol, poisons, hazardous industrial chemicals, and pharmaceuticals are the products most commonly regulated by law. Typically, their manufacture, packaging, advertising and promotion, and distribution may be controlled either by specific laws, or by regulations authorised by general laws. In such cases, the regulations can usually be changed from time to time by the government or parliament without new legislation having to be passed. Such procedures are part of the normal responsibilities of a government in protecting the welfare of its citizens. Laws giving government departments such powers are called *enabling laws*.

In most countries, however, tobacco escapes regulation, despite its many dangers, because in the eyes of the law it does not qualify as any of the products listed above. In effect, the tobacco industry has had the best of both worlds: no liability, but no real regulations either.

There is some evidence that in certain countries steps have been taken to classify tobacco as, for example, a pharmaceutical product, so that it would automatically fall within the provisions of legislation which gives the government power to regulate it, but the tobacco industry has almost always managed to defeat such moves.

A notable exception, still to pass the ultimate test of litigation, is the recent decision by the United States Food and Drug Administration to regulate nicotine as a drug and tobacco products as drug delivery devices. This may in due course have important implications for other countries.

Development of litigation

There have been two main types of action:
- Actions brought by health care providers seeking to recoup the costs of treating smokers
- Those brought by or on behalf of individuals injured by their smoking, often as "class action" suits, where an entire class of people—in this case, smokers suffering from smoking-induced disease, or those still addicted to smoking—are deemed to be potential litigants, and legal action is taken on their behalf, as a "class" or group.

Actions brought by health care providers

The first sort of cases began to be taken in the mid 1990s in the United States, when state authorities sued the companies to reclaim the cost of treating smokers injured by their habit. State Medicaid health schemes have, according to the state attorneys general who have initiated the suits, borne much greater costs than they would have done if the tobacco companies had acknowledged their products' lethal properties, stopped promoting them, and taken responsibility for the addiction and ill health suffered by their customers.

At the time of writing, a number of these cases have been resolved by out-of-court settlements, with the companies effectively admitting liability and agreeing to pay sums totalling many billions of dollars.

Variations of this type of case include:
- Legal action by labour union health care schemes

- Cases brought by contracted providers of public health care, such as Blue Cross and Blue Shield in the United States.

Actions brought by individuals

The second type of case involves the smokers themselves, or their families (in cases where the smokers have died), suing for damages. Although examples of such cases began in the 1980s, many are still ongoing, and likely to run for many years to come.

Encouraged by progress in the United States, lawyers and health workers in Europe and elsewhere have been following a similar route; in 1998, trials were ongoing in a number of European countries, including France, Israel, and the United Kingdom.

Tobacco industry response, and the development of litigation

Initially, the tobacco companies challenged the assertion that smoking had been proven to be harmful, and said that even if it was, smokers had been warned (cynically using the statutory health warning to absolve themselves from liability). Further, they claimed that smokers should have quit smoking if they believed that it was harmful.

For many years, with such lines of defence repeatedly letting them escape liability, the companies even boasted that they were impervious to legal action, and had never paid out a single cent in damages. However, in the United States, plaintiffs' lawyers gave their services free on the basis that they would earn a significant proportion of substantial damages if they eventually won a case.

With this type of legal backing, cases continued to be pursued, even after repeated decisions in favour of the industry, and two things began to happen:

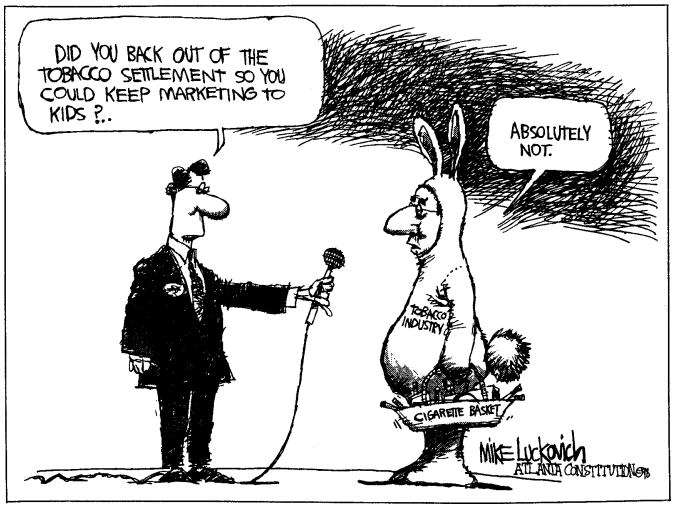
- Internal tobacco company documents began to be released, by order of the courts, a process known as "discovery". Many of these documents illustrated the wide variety of dishonesty and deliberate misinformation activities in which the companies had engaged
- Former tobacco company employees began to come forward to give evidence against their former employers.

It is appropriate to note that current and former industry employees had previously tended to remain silent because of the fear of retribution, a very real fear in the light of court actions, private detective investigations, and smear campaigns orchestrated by the companies against some early "whistle-blowers".

However, increasing evidence against the companies, and increasing public anger at their behaviour, encouraged more former employees to testify, which in turn generated further damaging evidence about the companies.

The hardening of public opinion against the companies led to increased political commitment to taking action, in place of a previous reluctance to harm what had been one of America's most powerful industries, and one of the most consistently generous in its financial contributions to politicians.

This trend was no doubt a factor in state attorneys general—political appointees—deciding to sue the industry, in turn generating further blizzards of internal industry documents, some of them highly damaging to the companies' case.



By Mike Luckovich of the *Atlanta (Georgia, USA) Constitution*. Reprinted by permission of Creators Syndicate.

In 1997, faced with a spiralling list of lawsuits, and the release of seemingly ever more incriminating evidence against them, the big American cigarette companies negotiated a settlement agreement, whereby, for a substantial sum (over US$300 billion, in lieu of damages for state health care costs, plus future health education programmes), they would be exempt from most future lawsuits.

The industry wanted stability and an end to an apparently bottomless pit of liability, but it also wanted to stop further incriminating evidence emerging, which might in due course harm its overseas sales.

Health campaigners pointed out that even a bill of hundreds of billions of dollars could easily be passed on to smokers as a price increase—in the United States, cigarettes traditionally have been much cheaper than in many other industrialised countries.

A massive lobbying and public relations exercise began, with the industry clearly desperate to get politicians to agree to the draft settlement and enact it as law. Further damage was suffered, however, through documents still being released in state lawsuits, and members of the United States Congress started to frame amended versions of the settlement involving higher damages and less future protection for the industry.

In April 1998, the companies decided to pull out of the settlement, and after the failure of a serious attempt to implement a substitute set of measures in Congress, the industry and state attorneys general began a fresh set of negotiations. This time the motivation of the states seems to have been much more that of money than a serious desire for public health gains, and a master settlement agreement was reached.

The role of doctors in litigation

Doctors have an important role in litigation. They have played leading roles in both main types of trial, by:

- Testifying as expert witnesses, in their roles as public health doctors and epidemiologists, about the proof of smoking as a cause of disease
- Appearing in personal injury cases, as physicians who have examined the injured smokers, giving their opinions about smoking as a cause of the patients' ill health.

No doubt many more doctors will be called to give evidence in such trials. The tobacco companies' tactics may change in countries where they suffer legal or political defeat, but elsewhere they may continue to pursue the most aggressive defence possible, with their virtually unlimited budget for legal expenses.

Under the companies' rules of engagement, every avenue is explored, however remote the chance of its success in defeating the action, or however distasteful it may seem. This can include attempts to discredit the plaintiffs and their witnesses.

NMAs can play a leading role in raising the issue of litigation, and in taking action to try to foster it. They can, for example:

- Host meetings of the relevant leading legal specialists
- Encourage doctors to form professional links with groups of lawyers pursuing legal action
- Brief financial analysts and journalists, to gain publicity for the concept of litigation, with incidental reinforcement of the perception of tobacco as a uniquely dangerous product.

In the European Region, a number of medical associations have already shown an interest in facilitating litigation against the tobacco industry, among them the British Medical Association and the Israeli Medical Association.

Release of industry documents

By far the greatest benefit to public health of litigation so far has been the release of several million internal tobacco industry documents. These are invaluable not only for further litigation, but also for countering tobacco industry misinformation in many of the routine situations encountered daily in every country.

The papers offer hard evidence of, among other things:

- Systematic deception by the industry about health issues
- Manipulation of nicotine to addict smokers
- Deliberate promotional targeting of children
- Organised creation and dissemination of false scientific evidence, especially about the dangers of passive smoking
- Payments to politicians and others influential people and organisations, to prevent the implementation of effective tobacco control measures.

Many of these papers have already been sifted and catalogued, and details of how to access them (often via internet web sites) can be obtained from various international health agencies.

WHO is understood to be considering the acceleration of this process as part of its Tobacco Free Initiative, to help tobacco control efforts worldwide.

Other forms of litigation

Two other aspects of litigation, referred to earlier, should be noted:

- Cases brought by individuals, usually against employers, claiming that they were exposed to tobacco smoke over many years, and suffered ill health because of it
- The potential threat from those who may in future try to sue their doctors, claiming they were not adequately advised to stop smoking.

In the first type of case, doctors may be asked to assess the degree of probability that the patient's disease was caused by passive smoking; and in the second, doctors may have to show that they did all that was reasonably possible to encourage and to assist their patients to quit.

Tobacco control legal groups

There is now a substantial body of expertise on legal aspects of tobacco control. Much of it is in the United States, where there is a well established tobacco litigation lawyers' group, with its own publication and meetings. Elsewhere tobacco control advocates and interested lawyers keep in regular contact. The international journal *Tobacco Control* (BMJ Publishing Group, see Appendix 3) covers major legal developments.

As with other aspects of international interest, NMAs can now quite easily make contact with others who have the experience and the motivation to assist with enquiries about litigation.

Appendix 1 Introducing a non-smoking policy for national medical association staff

As noted in Chapter 9, the introduction of a non-smoking policy for staff working for the NMA should be approached in the same way as is recommended for any workplace. The basic procedures are outlined below, and reference should also be made to pages 47–48 (smoking in public places) in Chapter 11, which highlights the special considerations affecting workplace smoking restrictions.

Basic steps to a non-smoking policy

The approach to be taken may vary slightly from country to country, in line with employment law, but overall the approach should be similar.

- The medical association should appoint a coordinator who should have the skills and authority to handle the process of negotiating and implementing the policy
- A working party should be set up, representing all groups concerned, including some smokers
- There should be a period of consultation and education
- The driving force for the proposed change should be that of a "health and safety at work" issue, just like other important issues in this category—for example, removal of asbestos building materials
- The minimum overall objective should be to guarantee non-smokers the right to breathe air free from tobacco smoke while they are at work, while taking account of the needs of those who cannot or will not stop smoking.

The following notes and comments are offered on the broad strategy outlined above.

Negotiation does not imply that if a majority of employees oppose eliminating smoking from the offices, that they can obstruct it, but that there is a process of hearing their views and arranging how they will cope with the new rules.

This may mean arranging smoking areas, or procedures for how and when they can smoke during routine breaks in their working day.

The NMA will want to be reasonable in its treatment of those who are dependent on smoking; and employment law is likely to require a reasonable approach to be taken with regard to what is, in effect, a change in the conditions of employment of the staff.

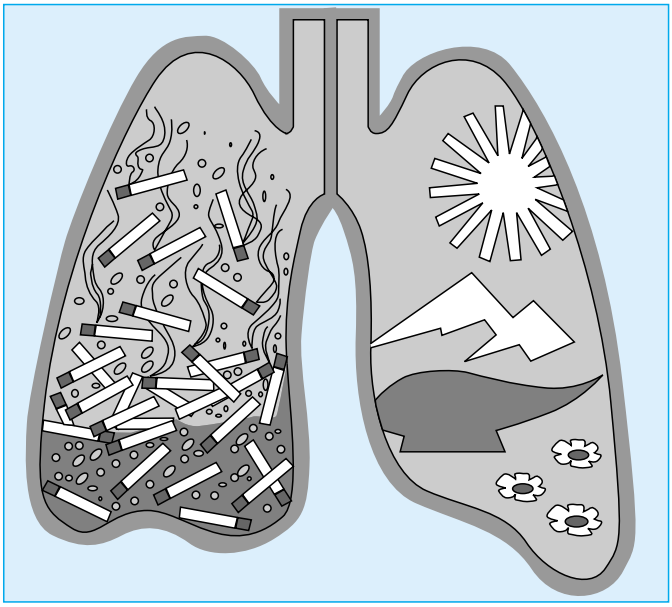
Smoking and employment law

The NMA should consult other health agencies which may have investigated the way employment law affects non-smoking policies.

If there is no record of expert opinion from employment law specialists, the NMA may wish to consider obtaining it, and publishing the results to help other employers to implement similar policies.

Although employment law requirements may dictate some of the consultation process, other legal requirements must be borne in mind, and will form the legal backing for the decision to make the premises smoke-free. Of these the most important will be one found in various forms in most countries: the general duty of employers to provide a safe working environment for employees. In some countries this may be specified in detail, including defined indoor air quality standards, but in others there may be less precise definitions.

The evidence of the dangers of prolonged exposure to environmental tobacco smoke is now so substantial that it must be regarded, at the very least, as a hazard of involuntary exposure from which people should be protected.



Accentuate the positive: workplace bans give freedom from tobacco smoke and protect people's health.

Informing the staff

Full use should be made of all methods of communication with the staff to explain the decision to implement the new policy. It will be more acceptable to introduce the concept for discussion in advance of a programme for change being finalised

The group should explain to the staff that:

- Scientific evidence shows that prolonged exposure to other people's tobacco smoke is a serious health hazard
- The NMA has decided it must remove this risk from the staff.

Staff should also be told about the other important reasons for the change:

- Doctors provide a role model within the community, and so does their NMA
- The benefits to smokers and the NMA of staff stopping or cutting down smoking (both of which are likely after the change): lower costs of cleaning and maintenance; less sickness absence; lower fire insurance premiums (and health insurance, where applicable).

The staff's opinion should be canvassed, but without giving the impression that a majority view will prevail: this is clearly as inappropriate as it would be for, say, the majority view to be allowed to determine new food hygiene standards, or fire safety precautions.

Health must come first

In other areas where health and safety are concerned, national standards are set, ultimately enforceable by law, and ideally, protection from tobacco smoke should be implemented in the same way. This concept should be the basis of the NMA's own policy.

Implementation

The working group should formulate details of:

- How and when the policy should be implemented
- "No smoking" signs to be erected
- Advice and possibly counselling to be arranged for smokers who want to quit
- If appropriate, and if space is available, provision for those who cannot or will not quit to smoke in certain designated smoking areas where non-smokers are not affected.

A policy should then be produced, publicised and comments solicited. After any amendments have been made in the light of such consultations, provided they are consistent with the overall declared aim:

- A date should be announced for its implementation
- Signs should be erected
- Notice should be given to staff and visitors that the building is a no-smoking area, with designated smoking areas if considered appropriate (many would say it was inappropriate for the NMA to allow smoking at any time, except perhaps in a phasing-in period)
- The policy should be rigorously monitored and enforced.

In practice, the adoption of non-smoking as the norm at the workplace is a relatively straightforward matter, provided care is taken to work methodically and take into account the perceived magnitude of the changes which will have to be made by smokers. If some smoking staff have been accustomed to smoking at their workplace whenever they feel like it, it is important (and may be required by law) to introduce the measures only after adequate notice, consultation and explanation.

Tips for success

There are a number of important tips to remember during any process of making premises smoke-free, to ease its implementation and to resist any opposition.

Emphasise that the new policy is:

- Not a move against smokers, but only against smoking (especially passive smoking), because of its harmful effects
- Not about whether someone smokes, but where and when they smoke.

Avoid all negative associations. Although it must be made clear that smoking will be banned, which to smokers is a negative concept, positive language must also be used:

- The NMA is acting to improve the health and welfare of all its staff and all other people who use its premises
- It is creating a smoke-free environment, giving freedom from tobacco smoke, protecting people's health, and setting a good example; these are very positive concepts.

Bad views of better health?

It may be necessary to correct the negative way in which some smokers and other commentators (including those with pro-tobacco interests), may present a non-smoking policy. Typically they will ignore the health reasons for the policy, even though, in another situation, the same commentators might draw attention to the risks of other indoor pollutants, such as asbestos particles. To counter this, a calm summary of the sound public health reasons for the policy must be reiterated.

Another common, negative comment is that smokers will not be able to use the newly smoke-free premises. For example, a newspaper headline might say: "Smokers banned from medical association offices". This is clearly nonsense: smokers will be as welcome in the offices as non-smokers. Smokers can still use the building, but they will not be able to smoke when they are in it, just as teachers who drink alcohol do not drink while in the classroom.

There are many places where smokers cannot smoke and fully accept the restriction: for example, churches, food shops, and factories. The NMA tobacco group should think of such comparisons in advance of any corrective press comment that may be required.

Appendix 2 Code of practice on tobacco-funded research

As noted in Chapter 7, a code of practice on tobacco funding of research has been developed by one of Europe's largest cancer research charities, the Cancer Research Campaign (CRC) of the United Kingdom. The code has been circulated widely to government and voluntary agencies which fund scientific research, and has been endorsed by many of them, most significantly by the Committee of Vice-Chancellors and Principals. CRC's note to those who hold grants, or want to apply for them, explaining the code and how it affects grant applications, is reproduced below, together with the text of the Code.

Supplementary Conditions of Award April 1999
The Cancer Research Campaign is in the process of updating its Terms and Conditions for grant support. Applicants and Grantholders who are asked to sign up to the Campaign's Conditions when making an application or accepting a grant, should read the current Conditions of Award (dated December 1995) and note the Campaign's new policy on CRC funding into institutions in receipt of tobacco industry funding detailed below. This policy will apply to all new grants awarded after 1 April 1999 although not to existing CRC grants. The revised Terms and Conditions, incorporating the policy on tobacco industry funding for new grants plus other issues, will be completed shortly and circulated to all grantholders who will be asked to sign a new Undertakings form.

Tobacco industry funding to Universities and Institutions

In pursuit of its mission, the Campaign wishes to promote the highest ethical practices in scientific and medical research. Mindful, therefore, of the immense danger to health and life caused by tobacco, it wishes to do everything it can to avoid links, whether direct or indirect, with the tobacco industry, and to oppose tobacco promotion and use in all its forms. Therefore, with the endorsement of the Committee of Vice-Chancellors and Principals, the Campaign has developed the following protocol.

From 1 April 1999, the Campaign will not provide future research support i.e. new grant awards to any institution in which those who are or would be supported by Campaign funds are working in such proximity to others supported by tobacco industry funding that there is any possibility or likelihood that facilities, equipment or other resources will be shared. Funding in a quite different faculty or school of the university or institution is not covered by this protocol.

Tobacco industry funding includes funds from a company or group of companies engaged in the manufacture of tobacco goods; and funds in the name of a tobacco brand whether or not the brand name is used solely for tobacco goods; funds from a body set up by the tobacco industry or by one or more companies engaged in the manufacture of tobacco goods.

- Funding from subsidiary and associated companies unless they bear the offending name or it is intended or likely that the parent or associated company with such a name will publicise the funding
- Anonymous donation
- Legacies from tobacco industry investments (unless the names of a tobacco company or cigarette brand are associated with them)
- Funding from a trust or foundation no longer having any connection with the tobacco industry even though it may bear a name that (for historical reasons) has tobacco industry associations
- Donations given to the university for general use by the university entirely at its discretion.

Funding falling within this protocol covers money provided or used for all or any of the costs of the research, including personnel, consumables, equipment, buildings, travel, meetings, and conferences, running costs for laboratories and offices, but not meetings or conferences unrelated to a particular research project.

Appendix 3 Useful resources and contact details

Denmark

WHO Regional Office for Europe
Action Plan for a Tobacco-free Europe
World Health Organization
Regional Office for Europe
8, Scherfigsvej
2100 Copenhagen
Contact: Dr Peter Anderson, Regional advisor
Tel: +45 3 917 1435
Fax: +45 3 917 1854
Email: pan@who.dk
Web site: www.who.dk

France

International Non-Governmental Coalition Against Tobacco (INGCAT)
68 Boulevard Saint-Michel
75006 Paris
Contact: Dr Karen Slama (kslama@worldnet.fr)
Tel: +33 1 44 32 03 60
Fax: +33 1 43 39 90 87
Email: info@ingcat.org
Web site: www.ingcat.org

Sweden

European International Network of Women Against Tobacco (INWAT)
National Institute of Public Health
Tobacco Control Programme
S-103 52 Stockholm
Contact: Margaretha Haglund
Tel: +46 8 5661 3535
Fax: +46 8 5661 3505
Email: margaretha.haglund@fhinst.se

INWAT is a network dedicated to supporting and uniting women in actions to prevent tobacco use among women. INWAT's three major objectives are to counter the marketing and promotion of tobacco to women, to develop programmes that help girls and women to resist starting or to give up smoking, and to promote women's leadership in the tobacco control movement.

Switzerland

GLOBALink
International Union Against Cancer
3 rue du Conseil-General
1205 Geneva
Contact: Ruben Israel
Tel: +41 22 809 1850
Fax: +41 22 809 1810
Email: israel@uicc.org
Web site: www.globalink.org

International Union Against Cancer (UICC)
3 rue du Conseil-General
1205 Geneva
Contact: Isabel Mortara
Tel: +41 22 809 18 11
Fax: +41 22 809 18 10
Email: info@uicc.org
Web site: www.uicc.org

Tobacco Free Initiative (TFI)
World Health Organization
1211 Geneva 27
Contact: Derek Yach, Project Manager
Tel: +41 22 791 2108
Fax: +41 22 791 4832
Email: yachd@who.ch
Web site: www.who.int/toh

United Kingdom

ASH (Action on Smoking and Health)
102–108 Clifton Street
London EC2A 4HW
Contact: Clive Bates, Director
Tel: +44 20 7739 5902
Fax: +44 20 7613 0531
Email: action.smoking.health@dial.pipex.com
Web site: www.ash.org.uk

Cochrane Tobacco Addiction Group
ICRF General Practice Research Group
Division of Public Health and Primary Care
Institute of Health Sciences
Old Road, Headington
Oxford OX3 7LF
Contact: Mrs Lindsay Stead, Coordinator
Tel: +44 1865 226997
Fax: +44 1865 227137
Email: lindsay.stead@dphpc.ox.ac.uk

This group is part of the Cochrane Collaboration, which prepares, maintains and promotes the accessibility of systematic reviews of the effects of health care. Abstracts of reviews by the Tobacco Addiction Group are at:
http://hiru.mcmaster.ca/cochrane/cochrane/revabstr/g160index.htm

Health Development Agency (HDA)
National Smoking Education Programme
Trevelyan House
30 Great Peter Street
London SW1P 2HW
Contact: Dr Ann McNeill
Tel: +44 20 7413 1900
Fax: +44 20 7413 2632
Email: ann.mcneill@hea.org.uk
Web site: www.hea.org.uk

International Agency on Tobacco and Health (IATH)
24 Highbury Crescent
London N5 1RX
Contact: David Simpson
Tel: +44 20 7359 7568
Fax: +44 20 7704 8086
Email: admin@iath.org

IATH is a non-governmental organisation which provides an information and advice service, including a detailed monthly information bulletin, to tobacco control colleagues in countries with fewer resources.

Tobacco Control: An International Journal
BMJ Publishing Group
Journals Marketing Department
PO Box 299
London WCH 9TD
Contact: Natalie Somekh, Marketing Executive
Tel: +44 20 7383 6862
Fax: +44 20 7383 6661
Email: nsomekh@bmjgroup.com
Web site: www.tobaccocontrol.com

Tobacco Control Resource Centre
c/o British Medical Association
BMA House
Tavistock Square
London WC1H 9JP
Contact: Lucien Rivière, Information Officer
Tel: +44 20 7383 6754
Fax: +44 20 7554 6754
Email: lriviere@bma.org.uk
Web site: www.tobacco-control.org

United States

Advocacy Institute
1707 L Street, NW, Suite 400
Washington
DC 20036
Contact: Theresa Gardella, Manager
Tobacco Control Project
Tel: +1 202 659 8475
Fax: +1 202 659 8484
Email: tgardella@advocacy.org
Web site: www.scarcnet.org

American Medical Association (AMA)
515 North State Street
Chicago
Illinois 60610
Contact: Dr Tom Houston, Director
Department of Preventive Medicine
Tel: +1 312 464 5957
Fax: +1 312 464 4111
Email: houston@globalink.org
Web site: www.ama-assn.org

Office on Smoking and Health
National Center for Chronic Disease Prevention and Health Promotion
Centers for Disease Control and Prevention (CDC)
Mail Stop K-50
4770 Buford Highway NW
Atlanta
Georgia 30341-3724
Contact: Samira Asma
Tel: +1 770 488 5719
Fax: +1 770 488 5939
Email: sea5@cdc.gov
Web site: www.cdc.gov/nccdphp/osh/tobacco.htm

World Bank
Centers for Disease Control and Prevention
Health, Nutrition and Population
Room S-9065
1818 H Street, NW
Washington, DC 20433
Contact: Joy de Beyer, CDC Liaison
Tel: +1 202 458 7616
Fax: +1 202 522 3489
Email: jdebeyer@worldbank.org
Web site: www.worldbank.org

Index

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