
The Role of the Family Physician in Ending the Tobacco Pandemic

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WARNING: This issue of the Journal may be hazardous to your preconceptions about the proper role of the family physician in counteracting the use and promotion of tobacco.

Smoking has ceased to be a health controversy and is now primarily a political issue that must be tackled by political means.¹

At first glance, it would appear that considerable progress has been made in clearing the air over tobacco in the past decade. Indeed, in the early 1980s few hospitals, schools, government buildings, restaurants, or other public places were smoke-free. Airlines prohibited smoking only on take-offs and landings; in between, the atmosphere was as polluted as a saloon. The National Cancer Institute had only recently ended its misbegotten research program to find a safer cigarette.² Countless television advertisements for a new and easier to use brand of spitting tobacco, Skoal Bandits, were broadcast during sporting events, including the Olympic Games.³ Few if any women's organizations or minority group associations took a public stance in opposition to cigarette advertising. The American Medical Association still held several million dollars in tobacco stocks.⁴ (The AMA sold all of its tobacco stocks by the end of 1981.) Not a single medical journal was devoting significant editorial space to the subject of tobacco use and promotion.

As the very existence of this issue of the Journal attests, modest progress is being made—much of it involving family doctors—in smoking cessation, in foster-

ing a clean indoor air environment, and in restricting access by adolescents to tobacco products. Unfortunately, all too many physicians still believe that most adverse health behaviors can be attributed to peer pressure and poor parental modeling rather than to the increasing barrage of youth-oriented advertising propaganda for unhealthy products. For example, more than \$3.6 billion is now spent annually in the United States alone to promote cigarettes,⁵ in stark contrast to the virtual absence of paid mass media space to discourage tobacco use. Smoking thus continues to go unrecognized by the public as far and away our leading preventable health problem, and cigarettes remain the most heavily promoted product in America.⁶

The biggest barrier to tackling the tobacco pandemic, then, is complacency—on the part of health professionals and the public alike—stemming from the belief that the war on smoking has been won. Although there is hardly a child or adult who has not heard that smoking is dangerous to health, the fact remains that the prevalence of smoking has declined by only 0.5% per year in the United States during the past decade; moreover, women, blue-collar workers, adolescents, and minority groups in general have not appreciably reduced their cigarette consumption.⁷

With rare exceptions, governmental agencies, health organizations, and academic institutions have not exerted leadership in efforts to reduce the social acceptability of smoking and its promotion. This role fell to a remarkable grassroots movement that arose in the 1970s with the goal of creating smoke-free public places: groups such as ASH (Action on Smoking and Health) and GASP (Group Against Smoking Pollution) paved the way for the federal ban on smoking in aircraft as well as for hundreds of local laws that restrict smoking, prohibit cigarette vending machines, and ban the free distribution of tobacco samples.⁷

Similarly, the efforts of DOC (Doctors Ought to Care) since 1977 to tap the highest possible level of

Submitted May 4, 1992.

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commitment on the part of all health care professionals in counteracting the promotion of lethal lifestyles have impelled the American Academy of Family Physicians and the American Medical Association to oppose cigarette advertising and to assist members in increasing their health promotion activities.

DOC grew out of a deficiency in predoctoral and residency training programs, its primary focus on the prevention of disease, whether involving patients in the office, children in school, or groups of individuals in the community at large. From the outset DOC sought to "lighten up" traditional health education approaches by encouraging students to parody popular commercial images for unhealthy products, with the aim of engaging young people to turn the tables on Madison Avenue. Thus was born the annual Emphysema Slims Tennis Tournament at the Medical College of Georgia and other medical schools, an ongoing series of demonstrations or "house calls" by physicians and medical students at events sponsored by tobacco companies, a national "Tar Wars" contest for children to create counter-advertisements to tobacco promotions,⁸ and a variety of humorous posters and other materials for the clinic waiting room.

But while physicians and medical students have been challenged by DOC to play a larger preventive role in their communities, old myths die hard. Not unlike the old saw "A woman's place is in the home," too many physicians still believe that their only place is in the examining room or hospital ward.

At the Seventh World Conference on Smoking and Health in Perth, Australia in 1990, Dr Ernst Wynder, one of the foremost early researchers on tobacco and cancer, bemoaned the apathy of the medical profession through the years in regard to addressing the problems of smoking.⁹ At the succeeding world conference in Buenos Aires earlier this year, there were fewer than 50 physicians in attendance out of more than 1000 registrants.

There remains a paucity of curricular time and materials on smoking in both medical schools and residencies, not only in regard to the epidemiologic, physiologic, and pathological aspects, but also in terms of instruction in ending tobacco use on an individual basis and in the community at large. Thus, although McIlvain et al¹⁰ report in this issue of the *Journal* that a training program for family practice residents in smoking cessation counseling skills did not lead to a sustained involvement in such techniques, their effort to enhance the skills of family physicians is in itself commendable. Similarly, the article by Narce-Valente and Kligman¹¹ to encourage family practice residents and faculty to document and discuss the subject of passive smoking with parents of young children is an important contribution. Kottke et al¹² continue to refine their Doctors Helping Smokers

program with the aid of Blue Cross of Minnesota; one can surmise that several elements of their approach will eventually be incorporated into every family practice. In regard to the hospital environment, the survey by Goldstein et al¹³ of five hospitals in Augusta, Georgia, 4 months after the implementation of a smoke-free policy found widespread violations of the smoking ban and a lackluster commitment on the part of physicians and nurses to dissuade patients from smoking. Moreover, while the decision by the Joint Commission on the Accreditation of Healthcare Organizations to require a smoke-free policy in 1992 as a condition of accreditation is likely to benefit the health and safety of employees and patients alike, family physicians risk becoming complacent if they assume that the absence of smoking in healthcare facilities reflects a true decline in tobacco consumption. Physicians should remind hospital administrators that instead of merely setting up and promoting a new smoking cessation clinic, they should take an aggressive role within the business community in countering the promotion of tobacco.

There is a great need for a no-holds-barred new vocabulary, that is, a new set of terms, images, and other symbols, with which to communicate to the public about tobacco products and manufacturers. To enhance such awareness, health care professionals would do well to view the leading preventable cause of death as Marlboro rather than as heart disease, lung cancer, or emphysema. More than 340 billion Marlboro cigarettes were smoked worldwide in 1991.¹⁴ Twenty-six percent of all cigarettes sold in the United States are Marlboro, and the percentage of market share rises dramatically among adolescents.¹⁴ Although spokespersons for Philip Morris, maker of Marlboro, point out that the company manufactures more than 3000 different products, the profit from this single brand of cigarettes is many times greater than the combined profits of its enormous Kraft General Foods subsidiary.¹⁴

Thus the tobacco pandemic is not a static concept, whereby one gives information about adverse health effects of smoking in the hope that individuals will change their behavior, but rather a dynamic one whereby the tobacco industry changes its tactics and its very identity to anticipate all efforts to limit tobacco use. The tobacco industry should be respected and studied much like the human immunodeficiency virus, which alters its antigenic coat to outwit the host organism. For example, while public health officials publicize the cheering notion—by means of prevalence data—that smoking is declining in the United States, the reality is that the number of Americans who smoke has remained constant at an excess of 55 million.¹⁴ In addition, American tobacco companies are dramatically expanding their markets in Europe, Asia, Africa, and Central and South America.¹⁵ Similarly,

as smoking has become less fashionable among upper- and middle-income groups, the tobacco industry has become increasingly adept at defining a profitable market among ethnic minorities.¹⁶ Through ubiquitous cigarette advertising on billboards and in stores in minority communities, along with tobacco company sponsorship of street fairs, music festivals, and cultural exhibitions, smoking retains an image of wealth and sophistication among the poor, uneducated, and disenfranchised. Unfortunately, since most physicians seldom spend time in low-income neighborhoods, they are not exposed to such substantial tobacco industry propaganda and may underestimate its impact on health.

Nowhere have cigarette advertisers been more successful in creating a positive association with tobacco than through sports sponsorship. By renting billboard space at key locations for TV cameras in 21 of the 24 US major league baseball stadiums, and by placing tobacco product logos on race cars, motorcycles, and drivers' uniforms, the tobacco industry continues to circumvent the law prohibiting cigarette advertising on television.¹⁷ (Family physicians have been in the forefront of monitoring and exposing this practice, as well as on the leading edge of research into the effects on children of the tobacco companies' use of cartoon characters in certain cigarette advertising campaigns.) Although the survey by Sinusas et al¹⁸ in this issue of the *Journal* on the use of spitting tobacco by major league baseball players confirms previous reports of widespread abuse of this substance, it is disappointing that the authors did not delve beyond "peer pressure" into the root cause of this phenomenon. While overt television commercials for cigarettes ended in 1971, advertisements for smokeless tobacco products were not ordered off TV until the mid-1980s.³ In the meantime, the United States Tobacco Company, the leading manufacturer of spitting tobacco, employed a team of baseball and football players, rodeo stars, race car drivers, and country music celebrities to endorse the use of its Skoal and Copenhagen brands.³ Today, in spite of the TV advertising ban, millions of young viewers each week are treated to stock car races, tractor pulls, rodeos, and fishing shows that prominently display the logos of various brands of spitting tobacco.¹⁹

What can family physicians do about such blatant disregard for public health? Heeding the alarm on snuff-dipping among adolescent athletes sounded well over a decade ago by the dental profession, physicians must work more closely with athletic coaches in secondary schools and universities to counteract tobacco use and promotion. On a local level, they can testify in favor of laws that prohibit the free distribution of tobacco samples, photograph and otherwise monitor the sports and cultural sponsorship marketing activities of local tobacco

distributors, lead boycotts of stores—especially pharmacies—that still sell and display advertisements for these carcinogenic products, verify that health and educational institutions neither hold stock in tobacco companies nor accept monetary support from them, and, along the lines suggested by DiFranza in this issue of the *Journal*, support strict legislation to penalize retailers for selling tobacco to minors.²⁰

On a national level, physicians should pressure their medical societies to withhold financial support from political candidates who accept funding from tobacco companies, and they should write en masse to their elected representatives, the US Attorney General, and the Federal Trade Commission to enforce the laws banning tobacco product advertising from television. To even imagine a smoke-free society, family physicians and other health care professionals must begin to expand their vision beyond the steady stream of individual patients passing through their clinics to a plan for preventing further encroachment of the tobacco industry on their communities.

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