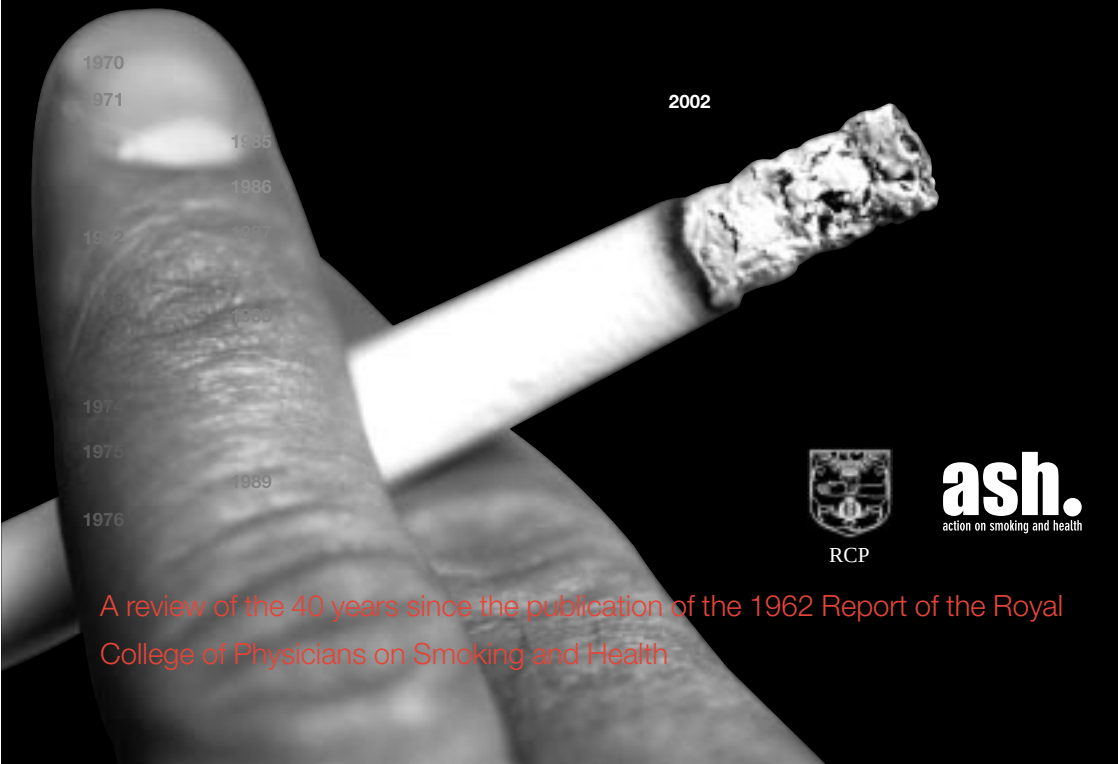
FORTY FATAL YEARS



RCP

ash. action on smoking and health

A review of the 40 years since the publication of the 1962 Report of the Royal College of Physicians on Smoking and Health

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Foreword

The humble cigarette is responsible for a dozen times more deaths in the UK in the past 40 years than British casualties from World War II – over 5 million.

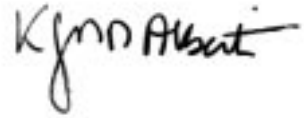
This is not a cold statistic, but a human tragedy. Five million people – people who deserved better; their lives ended prematurely by complicated patterns of disease, aided and abetted by the addictive power of nicotine, social attitudes and pressures, tobacco company marketing, and finally, years of Government inaction or half-hearted initiatives that failed to protect them from the consequences of smoking.

Yet it is a very different world to that of forty years ago. No-one alive at that time can forget the fug of train carriages and buses, the unapologetic lighting up next to babies and children, the unspoken assumption accompanied by the offering of a cigarette packet. It was into this world our report 'Smoking and Health' was launched, to bring to public attention the dangers of smoking and persuade the Government to do something about it. It was largely based on the ground-breaking research of Doctors (now Sir) Richard Doll and Austin Bradford Hill. As you will see from the following text, its recommendations immediately came up against ministerial indifference and inaction – a pattern to be repeated throughout almost all of the next forty years.

There have been some successful legislative measures and Government policy initiatives, but the major changes in smoking prevalence have come about as people themselves have taken on board public health messages and advice from their own doctors, made sensible choices about their health by giving up or not starting to smoke, and as a consequence will live longer and in a more pleasant environment.

This does not mean we can be complacent. Looking through the evidence in this booklet, I am deeply saddened by the lack of progress in tackling our biggest killer. The current Government is more committed to action against smoking than any before, yet it too has faltered and needs to be encouraged to put the public health of the nation first.

While it would be too much to hope that in forty years' time the humble cigarette will be confined to museums and historical dramas, I hope that my successor will be able to report much better progress in reducing this human tragedy of death and disease.



Professor Sir George Alberti

President of the Royal College of Physicians.

SMOKING AND HEALTH

Summary of a Report of
The Royal College of Physicians of London
on Smoking
in relation to
Cancer of the Lung
and
Other Diseases

LONDON
PITMAN MEDICAL PUBLISHING CO.LTD
1962

Introduction

Several serious diseases, in particular lung cancer, affect smokers more often than non-smokers. Cigarette smokers have the greatest risk of dying from these diseases, and the risk is greater for the heavier smokers. The many deaths caused by these diseases present a challenge to medicine, for in so far as they are due to smoking they should be preventable. This report is intended to give to doctors and others evidence on the hazards of smoking so that they may decide what should be done *(paras. 1-3)*.

History of Smoking

After its introduction to Europe in the 16th century, tobacco smoking, mostly in pipes, rapidly became popular. It has always had its advocates and opponents, but only recently has scientific study produced valid evidence of its ill-effects upon health. Cigarettes have largely replaced other forms of smoking in the past seventy years, during which time tobacco consumption has steadily increased. It is still increasing. Women hardly ever smoked before 1920: since then they have smoked steadily increasing numbers of cigarettes *(Figure 1, p, 3) (paras. 5-6)*.

Present Smoking Habits

Three-quarters of the men and half of the women in Britain smoke. Men smoke more heavily than women. Smoking is now widespread among schoolchildren, especially boys. *(Figures 2 and 3, pp. 5 and 7) (paras. 7-8)*. Many doctors have given up smoking since the dangers of the habit have become apparent: only half of them now smoke and less than a third smoke cigarettes *(Figures 4 and 5, pp. 9 and 11) (paras. 9 and 11)*.

Advertising of Tobacco. There has been a steep increase in expenditure on advertisements of tobacco goods recently. Over 11 million pounds was spent on such advertisements in 1960 *(Table 1, p. 6; Figure 6, p. 13)*. The increase has mostly been devoted to advertising cigarettes and many recent advertisements have been aimed at young people. It cannot, however, be assumed that advertisements are responsible for the continuing increase in tobacco consumption today *(paras. 10-11)*.

Chemistry and Pharmacology of Tobacco Smoke

Tobacco smoke is complex in composition. Its most important components are: nicotine which acts on the heart, blood vessels, digestive tract, kidneys and nervous system; minute amounts of various substances which can produce cancer; and irritants which chiefly affect the bronchial tubes. The amounts of carbon monoxide and arsenic in the smoke are probably too small to be harmful *(paras. 12-22)*.

Smoking and Cancer of the Lung

There has been a great increase in deaths from this disease in many countries during the past 45 years *(Figure 7, p.15)*. Some of this increase may be due to better diagnosis, but much of it is due to a real increase in incidence. Men are much more often affected than women. *(Table II, p. 14) (paras. 23-24)*.

Surveys. Many comparisons have been made in different countries between the smoking habits of patients with lung cancer and those of patients of the same age and sex with other diseases. All have shown that more lung cancer patients arc smokers, and more of them heavy smokers than are the controls. The association between smoking and lung cancer has been confirmed by prospective studies in which the smoking habits of large numbers of men have been recorded and their deaths from various diseases observed subsequently. All these studies have shown that death rates from lung cancer increase steeply with increasing consumption of cigarettes. Heavy cigarette smokers may have thirty times the death rate of non-smokers. *(Figure 8, p. 17)*. They have also shown that cigarette smokers are much more affected than pipe or cigar smokers *(Figure 9, p. 19)* and that those who had given up smoking at the start of the surveys had lower death rates than those who had continued to smoke *(Figure 10, p. 21)*. Various criticisms, based on possible errors of selection and of diagnosis, which might have caused a spurious association between smoking and lung cancer in these studies, are discussed *(paras. 25-29)*.

Pathology of Smokers' Lungs. Of three types of lung cancer, only the two commoner types are associated with smoking. The lungs of smokers without cancer show changes of chronic irritation, of the sort which might precede cancer, more often than the lungs of non-smokers *(paras. 30-31)*.

Interpretation of the Evidence. The association of lung cancer with cigarette smoking is generally agreed to be true but various possible explanations of this association other than that of cause and effect have to be considered These are (para. 32) :–

(i) that people who are going to get lung cancer have an increased desire to smoke throughout their adult lives:

(ii) that smoking produces cancer only in the lungs of people who are in any case going to get cancer somewhere in the body, so that smoking determines only the site of the cancer:

(iii) that lung cancer affects people who would have died of tuberculosis in former times but have now survived with lungs susceptible to cancer:

(iv) that smokers inherit their desire to smoke and with it inherit a susceptibility to some other undiscovered agent that causes lung cancer:

(v) that smokers are by their nature more liable to many diseases, including lung cancer, than the "self-protective" minority of non-smokers:

(vi) that smokers tend to drink more alcohol than non-smokers so that drinking and not smoking may cause lung cancer:

(vii) that motor car exhausts, or – (viii) that generalised air pollution may render the lungs of smokers more liable to cancer.

None of these explanations fits all the facts as well as the obvious one that smoking is a cause of lung cancer. There are other causes, including air pollution and substances which may be met in a few occupations, but none of them is of such general importance as smoking *(para. 33)*.There are a few facts which may be considered to conflict with this conclusion namely:–

(i) that lung cancer occurs in only a minority of smokers:

(ii) that death rates from this disease are lower in some countries than would be expected from their cigarette consumption:

(iii) that there is some conflicting evidence on the effects of inhalation of smoke:

(iv) that no animal has yet been given lung cancer by exposure to cigarette smoke.

Conclusion. These facts are discussed *(paras. 33-40)* and none of them is found

to contradict the conclusion that cigarette smoking is an important cause of lung cancer. If the habit ceased, the number of deaths caused by this disease should fall steeply in the course of time *(para. 41)*.

Smoking and Other Lung Diseases

Chronic bronchitis is a common and distressing disease in Britain and causes many deaths, especially in middle aged and elderly men. Smokers, particularly cigarette smokers, are much more often affected than non-smokers *(Figure 11, p. 29)*. Other agents, of which generalised air pollution is the most important, are involved and it may be that damage done to the bronchial tubes by cigarette smoke makes them more susceptible to these other agents. Many men and women who are now disabled by chronic bronchitis might have remained well had they not smoked *(paras. 42-50)*.

Smoking may possibly contribute to the development of pulmonary tuberculosis, especially in the middle-aged and elderly *(paras.51-52)*.

Smoking and Diseases of the Heart and Blood Vessels

Coronary heart disease is a more frequent cause of death in smokers, particularly cigarette smokers, than in non-smokers, although the latter are also commonly affected (*Table III, p. 34)*. Those who give up smoking have a reduced death rate *(Figure 12, p. 33)*. Many other factors, such as mental strain, sedentary occupation and diet, may explain some of the association of this disease with smoking, but cigarette smoking probably plays a significant part in rendering men in early middle age more liable to its serious effects *(paras. 53-57)*.

Smoking appears to play a part in causing other arterial diseases but not high blood pressure *(paras. 58-59)*.

Smoking and Gastro-intestinal Diseases

Smoking affects the movements and secretion of the gut in many ways and may cause symptoms such as nausea and discomfort. It depresses appetite and may reduce weight. It does not appear to cause gastric or duodenal ulcers but interferes with their healing *(paras. 60-65)*.

Cancers of the mouth, throat and gullet occur more frequently in smokers than in non-smokers *(para. 66)*.

Smoking and Other Conditions

Several relatively uncommon diseases occur more often in smokers than non-smokers *(paras. 67-69)*. Smokers may be more liable to accidents than non-smokers *(para. 70)*. Women who smoke tend to have babies that are underweight *(para. 71)*. Smoking may impair athletic performance *(para. 72)*.

The Psychological Aspect of Smoking

Very little is known about why people smoke. Children tend to follow their parents' smoking habits. Intelligent children smoke less than duller children. Adults claim that smoking gives a sense of relaxation, helps them to concentrate and gives them relief when they are anxious, but these claims are difficult to test. Psychologists have suggested various unconscious motives for smoking *(paras. 73-78)*.

Smokers tend to be more restless, less dependable and more neurotic than non-smokers. Cigarette smokers are more extroverted than non-smokers, pipe smokers are more introverted. That the tendency to smoke may be partly inborn is shown by studies of the smoking habits of twins *(para. 79)*.

Smokers may be addicted to nicotine. They may wish to stop smoking for a variety of reasons, chiefly because of expense or fear of ill health. It appears that social factors play a bigger part in determining smoking habits than internal drives or needs *(paras.80-82)*.

Conclusions

The benefits of smoking are almost entirely psychological and social. It may help some people to avoid obesity. There is no reason to suppose that smoking prevents neurosis *(paras. 83-85)*.

Cigarette smoking is a cause of lung cancer, and bronchitis and probably contributes to the development of coronary heart disease and various other less common diseases. It delays healing of gastric and duodenal ulcers *(paras. 86-89)*.

The risks of smoking to the individual are calculated from death rates in relation to smoking habits among British doctors *(Table IV, p. 44)*. The chance of dying in the next ten years for a man aged 35 who is a heavy cigarette smoker is 1 in 23 whereas the risk for a non-smoker is only 1 in 90. Only 15 per cent (one in

six) of men of this age who are non-smokers but 33 per cent (one in three) of heavy smokers will die before the age of 65. Not all this difference in expectation of life is attributable to smoking *(paras. 90-91)*.

The number of deaths caused by diseases associated with smoking is large *(Table V, p. 47) (para. 92)*.

The need for preventive measures. Reduction in general air pollution should reduce the risks of cigarette smoking; but it is necessary for the health of the people in Britain that any measures that are practicable and likely to produce beneficial changes in smoking habits shall be taken promptly *(paras. 93-95)*.

Preventive Measures

Since it is not yet possible to identify those individuals who will be harmed by smoking, preventive measures must be generally applied *(para. 96)*.

The harmful effects of cigarette smoking might be reduced by efficient filters, by using modified tobaccos, by leaving longer cigarette stubs or by changing from cigarette to pipe or cigar smoking *(paras. 97-102)*.

General discouragement of smoking, particularly by young people, is necessary. More effort needs to be expended on discovering the most effective means of dissuading children from starting the smoking habit *(paras. 103-107)*. There can be no doubt of our responsibility for protecting future generations from developing the dependence on cigarette smoking that is so widespread today.

Most adults have heard of the risks of cigarette smoking but remain unconvinced. Doctors, who see the consequences of the habit, have reduced their cigarette consumption. Some evidence of concern by the Government is needed to convince the public. The Government have so far only asked local health authorities to carry out health education in respect of smoking, but little seems to have been achieved. The Central Council for Health Education and Local Authorities spent less than £5,000 on anti-smoking education in 1956-60, while the Tobacco Manufacturers spent £38,000,000 on advertising their goods during this period *(paras. 108-111)*.

Possible Action by the Government

Decisive steps should be taken by the Government to curb the present rising consumption of tobacco, and especially of cigarettes. This action could be taken along the following lines *(paras. 112-119)*:–

(i) more education of the public and especially school-children concerning the hazards of smoking:
(ii) more effective restrictions on the sale of tobacco to children:
(iii) restriction of tobacco advertising:
(iv) wider restriction of smoking in public places:
(v) an increase of tax on cigarettes, perhaps with adjustment of the tax on pipe and cigar tobaccos:
(vi) informing purchasers of the tar and nicotine content of the smoke of cigarettes:
(vii) investigating the value of anti-smoking clinics to help those who find difficulty in giving up smoking.

Doctors and Their Patients

There are good medical grounds for advising patients with bronchitis, peptic ulcer or arterial diseases to stop smoking. Even a smoker's cough may be an indication that the habit should be given up. Doctors are better able to help their patients to stop smoking if they do not smoke themselves. They have a special responsibility for public education about the dangers of smoking *(paras. 120-121)*.

Forty Years Ago

David Pollock Director of ASH 1991-1994
Author: Denial & Delay: the political history of smoking and health, 1951-64

Forty years ago the Royal College of Physicians' report *Smoking and Health* was published. It had its origins in the Britain of the 1950s, an almost unrecognisably different place from today. Newspapers reported politicians' speeches at length and after they had been made, not opponents' reactions to advance leaks. Government had serious doubts about the propriety of trying to change adults' behaviour. Doctors could do so little about cancer that official policy was to avoid public education so as to avoid scares. Epidemiology was in its early days and widely discounted as "just statistics". The tobacco industry was a respectable giant, generating 14% of tax revenue. And 4 out of 5 men and almost 1 in 2 women were smokers.

The retrospective studies by Austin Bradford Hill and Richard Doll, published in 1950, which had in their view conclusively proved the link between smoking and lung cancer, went almost unreported in the press. The specialist committee advising the Minister of Health on cancer was unconvinced. When finally it agreed a ministerial statement was justified, its eminent chairman, a heavy smoker, remained a lone dissentient. A doctor at the Medical Research Council referred to the "great reluctance" of the Ministry's medical officers to accept the truth. The Chief Medical Officer ordered the draft statement to be toned down and qualified. The Cabinet, warned by the Treasury of possible disastrous effects if people stopped smoking, softened the draft even more.

When the Health Minister, Iain Macleod, finally met the press (in February 1954), he emphasised that the evidence was statistical only, thanked Doll and Hill for 'what little information we have' – and chain-smoked throughout the proceedings. He also announced that the tobacco industry had given £250,000 for research to the MRC. The press reported the uncertainty and the industry's generosity.

Two years later after further pressure for public education, the Cabinet ruled that the government should not 'assume too lightly the odium of advising the general public on their perceived tastes and habits where the evidence of harm. . . is not conclusive' and a new ministerial statement (May 1956) rejected the idea of any 'national publicity campaign'.

But the problem would not go away. The MRC produced a statement that concluded that 'the evidence now available is stronger than that which, in comparable matters, is commonly taken as the basis for definite action' – but not in this matter, so this troublesome conclusion was omitted from the published version. The Cabinet agreed a ministerial statement (June 1957) shorn of any persuasive language and based on denial of 'a "duty" to warn the public'. Responsibility for publicity was placed on local health authorities – but they were given no additional funds. The tobacco companies were shown the statement in advance, enabling them to produce a simultaneous detailed riposte.

The press gave heavy coverage to the new MRC and ministerial statements, emphasising as the Government had wished that 'It's Up To You' – the *News Chronicle* headline. That paper alone criticised the policy of complacency and quoted these exchanges from the ministerial press conference:

Q: Do you think lowering the death-rate from lung cancer would be a good thing?

A: Well (after a pause) I don't think it would be a bad thing.

Q: To achieve this will you tell the public they ought to stop smoking?

A: I think it is up to the public to make up its own mind from the facts they are given.

For the next four years, almost nothing happened. The local authorities asked for more cash and were refused it. Their Central Council for Health Education (CCHE) produced a few leaflets and posters – but when one of these, showing the smoke from a cigarette curling into the word 'cancer', was banned by the poster industry allegedly because it implied 'that one cigarette would cause cancer', the Ministry of Health declined to get involved and their representative at a CCHE meeting recorded:

I again drew attention to the interest the tobacco people might have in this poster, and that they might feel the poster was inimical to their interests.

This was far from the only occasion when Ministry of Health officials warned against offending the tobacco companies.

Pressure from the local authorities led eventually to further Cabinet discussion. The outcome was more delay while a survey was conducted to find out how effective the 'policy of bringing the facts to the notice of the public' had been. A pilot survey found that of 83 adults and 71 young people questioned, only one elderly non-smoker had not heard of the association of smoking and lung cancer. The fact that they were continuing to smoke was of no concern: the results showed so conclusively that the government had done its duty that the Cabinet decided in 1960 that no further action was needed.

There are at least three factors underlying this seeming complacency on the part of government. One was that the story the epidemiologists told was incredible: smoking was endemic and respectable. It was as if someone today were to claim proof that instant coffee caused senile dementia. There was little hard scientific evidence to back the statistics, and in 1960 a Ministry medical officer recorded that 'perhaps a majority of doctors' remained unconvinced by the evidence against tobacco. The second was that the industry was so important to the economy – and without any notion of the addictive power of nicotine the Treasury feared that people might stop smoking overnight. The third was the tight limits then placed on the proper role of government. Smoking was not infectious or contagious (an effective publicity campaign had been run against diphtheria since the early 1940s) and so the freedom of adults to make their own decisions was paramount. Local authority publicity directed at adults should merely state the facts: any mild persuasion against smoking was limited to schoolchildren.

There were of course those who took a different view. From the time the original Doll/Hill research appeared, Dr Horace Joules of the Central Middlesex Hospital had pushed relentlessly for action through the system of ministerial advisory committees. A handful of MPs had kept up parliamentary pressure, and a few local authority medical officers had against the odds produced some effective publicity. Now, however, they found heavyweight backing at last, as the Royal College of Physicians made its first intervention in a public health debate since it denounced cheap gin in 1725.

The idea originated in 1958 when Dr Charles Fletcher, a maverick who outraged many in the profession with his television series on surgery, *Your Life in their Hands*, spoke to Dr George Godber, then a Ministry of Health medical officer, deploring the Ministry's complacency. Godber proposed that they each approach the new President of the College, Robert Platt, to suggest a committee on smoking and health. Platt agreed readily and took the chair himself. Things moved slowly, however, and in the interim the forthcoming report was used as an excuse for continuing inaction by the Ministry, not least in dismissing a cogently argued paper from the Scottish Office that proposed a much more interventionist policy.

The report came out on 7 March 1962. Written for the ordinary reader, it gained wide press coverage and for once the industry, quixotically given an advance copy by the College, found that their spoiling press release and counter-report were given comparatively little attention. Cigarette sales fell and filter brands became more popular. The *Financial Times* said in a leading article that, although tobacco tax accounted for 14% of total public revenue, 'the financial aspect of the matter must firmly be given second place. The tax on cigarettes must be raised – not by a small amount . . . but by an amount so large as to risk an actual loss of revenue.'

Within days Enoch Powell, the Minister of Health, was subjected to tough Parliamentary questions and BBC TV broadcast a hard-hitting Panorama programme. Richard Dimbleby quoted Powell's statement in Parliament that the report 'demonstrates authoritatively and crushingly the causal connection' between smoking and lung cancer and quoted the report's finding that the risk of lung cancer for a smoker of 20 cigarettes a day was 16 times that of a non-smoker. Dimbleby, who was to die of lung cancer within four years, said he had quit his 40-a-day habit just six weeks earlier. Sir Robert Platt and John Partridge, managing director of Imperial Tobacco and chairman of the tobacco companies' joint committee, were interviewed by Robert Kee and clashed sharply. When Partridge called for more research, Platt hit back that the research had already been done – on living populations. Partridge defended tobacco advertising –

'to young people?' – 'Yes indeed . . . but not to children' – but found himself in difficulty when asked why children should not smoke if there was nothing harmful in it.

The Government's reaction was slower. Despite having an advance copy of the report for four months, they had no position prepared beyond a decision (at Treasury prompting) to omit from their initial reaction any reference to 'discouraging' adults from smoking. Lord Hailsham as Lord President of the Council (and so in charge of the Medical Research Council) chaired a Cabinet committee to consider the report's recommendations. The committee was supported by an interdepartmental committee of officials. Hailsham, a non-smoker, was enthusiastic: he had already shown himself worried at the Ministry's complacency two years earlier, and now he had in Powell a minister of health who was equally critical of the industry and keen on effective action: a cynical Board of Trade official recorded that Powell had 'clearly swallowed the Report hook' line and sinker' and that 'Lord Hailsham holds very strong personal views on the subject to which he intends to give free rein. In particular . . . he says that [the tobacco companies' response to the Report] was deliberately dishonest and wicked from start to finish'. Hailsham and Powell, however, were struggling against a huge weight of prejudice and inertia.

The Royal College had made seven recommendations for Government action. These were scrutinised by the interdepartmental committee, whose chairman Hailsham briefed in detail how to approach the task, throwing off suggestions and questions in profusion.

- The first recommendation was for public education. The Scottish Office proposed a £1 million campaign (about £13 million today) with a steering committee including representatives from the BMA, TUC, industry, education and so on. The committee recommended instead a £50,000 (about £650,000) three-year campaign using free media – posters, film-strips, leaflets and bookmarks made available to local health authorities. The latter also cooperatively operated three vans to tour schools and other venues with films and lecturers – headteachers praised the films but said the lecturers lacked expertise and enthusiasm. Three of the Ministry's posters were banned by the poster industry's Joint Censorship Committee who

would not accept any statement that cigarettes caused (as against might cause) cancer. The modest ambitions of this campaign were dictated not just by frugality with public money: the committee believed any mainstream advertising by the Government would be swamped by the £11 million advertising budget of the industry. There was also fear that the industry would embark on a counter-advertising campaign and 'it would be difficult to justify to public opinion what would be bound to appear as a conflict between Government policy and the tobacco companies' – a telling betrayal of officialdom's closer identification with the industry than with the public.

- The second recommendation was for 'more effective restrictions on the sale of tobacco to children'. The committee recommended 'as a political rather than a practical gesture' that fines be increased but rejected raising the minimum age to 17 or 18, controls on vending machines in public places and banning sales of fewer than ten cigarettes. They undertook a long examination of the idea of revocable licences to sell tobacco but rejected it on grounds of impracticality and administrative workload, sticking to this view even when Hailsham's ministerial committee asked for further consideration.

- The third was for restriction of tobacco advertising. There was already pressure in Parliament for a ban on cigarette advertising on the new commercial television channel, but the officials' committee thought such a ban unreasonable if advertising in the press and on hoardings remained unregulated. Capping the industry's advertising spend would be 'an invidious task', while a complete ban would lead to demands for the same treatment of alcohol. Altogether, it was best to seek voluntary measures by the advertising media and the tobacco industry while 'keep[ing] the threat of legislation in reserve'.

- The College next recommended wider restriction of smoking in public places, which had long been sought by the National Society of Non-Smokers – now transformed into Quit. The committee was half-hearted at best, but Hailsham's committee insisted on more sympathetic consideration.

- Increased taxation, especially on cigarettes – the fifth recommendation –

was rejected. Only a 'very substantial' increase would have any effect, and that would 'heavily penalise' the 'lower social classes', raise the cost of living and stimulate wage claims. When Hailsham's committee commissioned further consideration of the matter, the Treasury held out, citing the unfairness to the poor and to women (who could not switch to pipes or cigars) and the risks of evasion and of political unpopularity.

- The least considered recommendation of the College report was the printing of tar and nicotine yields on cigarette packets. The companies had already pointed out that the report itself said that no claim should be made that any brand was safer than any other, and the College had to admit that there was 'no scientific reason behind their recommendation'. The officials rejected it.
- Lastly the College recommended investigating the value of anti-smoking clinics. This was within the sole competence of the Ministry of Health, who proceeded to gather the scanty information available and to encourage health authorities to start some trials.

Hailsham's committee reported to the Cabinet in July 1962. A Board of Trade official later recorded gladly that 'with the exception of Lord Hailsham, Ministers, and especially the P.M., were pretty firmly agreed that they were not anxious to stick their fingers into this very difficult pie save to the limited extent of giving the "all clear" for the health and education campaign'. With such scanty results Hailsham had to concede there was no basis for the parliamentary statement he had planned.

The immediate fruits of the College report were therefore confined to a £50,000 publicity campaign and the beginnings of cessation clinics. But the report had started a number of hares. One was the first voluntary code on advertising, prepared – in words recognisable today – by the Independent Television Authority. Hailsham promptly persuaded the companies to apply it in all their advertising, and the Advertising Standards Authority, then just formed, was commissioned to administer it. Work on cessation gradually spread and expertise accumulated. When the US Surgeon-General's report was published

in 1964, the committee of officials resumed its work, forcing fresh consideration of all the rejected proposals. The idea of tobacco control was becoming familiar and less easy to dismiss. Random amateurism born of ignorance was yielding to a professional approach, and when Labour took power in 1964, Kenneth Robinson as health minister quickly won agreement to a ban on television cigarette advertising.

The prevailing inertia, however, was not fully overcome, and seven years later the Royal College of Physicians was driven to produce its second report and to encourage the formation of Action on Smoking and Health as a 'ginger group' to put pressure on the government. Nevertheless, we can look back on the original report as a turning point. It did more than all the Government's previous efforts over twelve years to educate the public about the dangers of smoking. It introduced the idea of a comprehensive programme of tobacco control. And it forced acceptance in Whitehall that there was a need for real action on smoking, rather than merely the appearance of action.

Then and Now

Clive Bates Director of ASH

When the Royal College of Physicians launched its 1962 report, *Smoking and Health*, smoking was almost ubiquitous in Britain – 70 per cent of men and 43 per cent of women smoked. Pipe smoking was still the chosen habit of about 13 per cent of men, but by the second half of the century it was the manufactured cigarette that dominated tobacco consumption in Britain.

Lives lost, cigarettes smoked

Even in 1962, male smoking was already in decline, from post-war rates of over 80 per cent. But among women, the peak rate of smoking was still a few years in the future – 45 per cent was reached in 1965. Smoking has been in a steady decline since then, with now 29 per cent of men and 25 per cent of women smoking. Despite this reduction in prevalence, over four trillion cigarettes will have been smoked in Britain since 1962, and over five million lives will be ended prematurely as a result of smoking over the 40-year period.

Lives saved, cigarettes not smoked

Looked at more positively, the reduction in smoking since the Second World War is one of the greatest advances in public health of the 20th Century in Britain. Had smoking rates persisted at the 1962 levels, life-expectancy in Britain would be lower and the NHS would be struggling under an even greater burden of cancer and heart and lung disease. The reduction in smoking prevalence in the last forty years represents about 300 million person-years of avoided smoking or, at an average of 15 cigarettes per day, approximately 1.6 trillion cigarettes (or equivalent) not smoked – amounting to about 1.6 million lives not ended by tobacco-related disease. With so much lost business, it is little surprise that tobacco companies mounted a desperate defence of their product.

Health, business and politics

The College's report did not introduce the idea that smoking was a cause of serious ill-health. That idea had gained currency in 1950 following publication of several papers linking smoking and cancer. The aim of the report was to try to resolve the controversy that followed, to dispatch the distracting counter theories, and to give the best possible advice and state of the art scientific knowledge at the time. Even in 1962, the College was engaged in a battle for the truth with the tobacco industry.

The report was aimed at 'doctors and others' so that they may 'decide what should be done'. It was not an academic curiosity but a call to arms, and an attempt to clear away the murky disinformation that was circulating even then about smoking and health. The political establishment at the time reacted in a way that would be very familiar to observers of the recent debacle over BSE. The College provided clear advice and guidance on a credible political response to the threat of smoking to public health. The government then, and most governments since, have simply done nothing or made token gestures. The Labour government elected in 1997 announced the first ever tobacco White Paper – *Smoking Kills*. This marked a step change in the political approach to tobacco and amounts to far more than ever came before. However, delivery has been slow, commitment uncertain and some policies have been dropped or delayed. The College continues to try to hold the government to account for its promises and to make the case for tobacco policy as a central component of health policy and NHS reform.

Science

Disease

The 1962 report gave a robust account of the evidence available showing that "cigarette smoking is an important cause of lung cancer"; that "many men and women now disabled by bronchitis might have remained well had they not smoked"; that "coronary heart disease is a more frequent cause of death in smokers" and that "several relatively uncommon diseases occur more often in smokers than non-smokers". These conclusions have not changed and since 1962 over 130,000 papers in peer-reviewed journals have added depth and breadth to the basic findings. Smoking is one of the most exhaustively researched phenomena and as research has delved deeper into the epidemiology, physiology and behavioural aspects of smoking it has established that over fifty diseases are caused or aggravated by smoking. Admissions by the tobacco companies that smoking was a cause of serious disease were not forthcoming until the late 1990s, and even then hedged in obfuscating language.

Confounding explanations for lung cancer

The report went thoroughly into the various hypotheses that had been advanced to explain the rise in lung cancer without attributing the cause to cigarette smoking – for example: *that smokers inherit their desire to smoke and with it inherit a susceptibility to some other undiscovered agent that causes lung cancer:* The analysis dealt carefully with each of seven similar confounding theories – only to dismiss them all. These theories persist to the present day, and the tobacco companies still continue to promote doubt about the causal relationship between smoking and lung cancer. For example, this is from British American Tobacco's web site in February 2002.

Traditionally, epidemiology has been used to identify associations that point to possible causes of a disease, providing direction for thorough laboratory investigations. With smoking, the many laboratory investigations over the years have proved more problematic, and science has not to date been able to identify biological mechanisms which can explain with certainty the statistical findings linking smoking and certain diseases, nor has science been able to clarify the role of particular smoke constituents in these disease processes. Science is still to determine which smokers will get a smoking related disease and which will not. Nor can science tell whether any individual became ill solely because they smoked. This is, in part, because all of the diseases that have been associated with smoking also occur in life-long non-smokers.

Addiction

The report also identified nicotine as the likely addictive agent in cigarettes. At this stage the finding was informed speculation: "smokers may be addicted to nicotine", but this was a view ahead of its time, and this has proved to be the central driver of smoking and the reason why some of the early policy advice was not effective.

The view that smoking is primarily a means of administering the addictive drug nicotine was overwhelmingly endorsed and hugely elaborated in the College's 2000 report Nicotine Addiction in Britain. The 2000 report concluded: *"Nicotine is highly addictive, to a degree similar or in some respects exceeding addiction to 'hard' drugs such as heroin or cocaine"*

Mortality

The 1962 report substantially underestimated the numerical risk of premature death through smoking – mostly because the full health consequences of the rise in cigarette consumption in the first half of the century had yet to become visible. In 1962, the British were incubating an epidemic of lung cancer, heart disease and respiratory illness arising from the high levels of post war smoking. By the 1990s it was clear that smoking-related disease such as cancer follows smoking prevalence with a lag of several decades for cancer, several years for heart disease.

Tobacco companies and the science

The publication of the 1962 RCP report did not stop the tobacco companies denying the link between smoking and ill-health or continuing to promote doubt where there was reasonable scientific consensus. In 2000, the House of Commons Health Select Committee conducted an in-depth review: *The tobacco industry and the health risks of smoking.* The committee concluded:

54. In analysing the past and present record of the tobacco industry's response to the health risks of smoking we have observed a pattern. It seems to us that the companies have sought to undermine the scientific consensus until such time as that position appears ridiculous. So the companies now generally accept that smoking is dangerous (but put forward distracting arguments to suggest that epidemiology is not an exact science, so that the figures for those killed by tobacco may be exaggerated); are equivocal about nicotine's addictiveness; and are still attempting to undermine the argument that passive smoking is dangerous. The current exceptions to this – based on the evidence they gave us – are firstly Philip Morris who claim no longer to comment on these issues except to protect themselves in law and secondly Imperial who claim not to know whether smoking is dangerous or nicotine addictive.

Policy response

The report called for government action to tackle the problem and said that action was urgent:

…it is necessary for the health of the people in Britain that any measures that are practicable and likely to produce beneficial changes in smoking habits shall be taken promptly.

Discouraging smoking among young people

The College called for preventative measures including a general discouragement of smoking and stated that *"more effort needs to be expended on discovering the most effective means of dissuading children from starting the smoking habit."* To its great credit, the College was reluctant to prescribe exactly how to tackle youth smoking. The prevailing public health wisdom today is that youth smoking is primarily a consequence of smoking in the adult world, and therefore teenage smoking is a rite of passage to adulthood. Efforts to tackle youth smoking directly risk making smoking seem more adult, and therefore more attractive to teenagers – this paradox has led most health professionals to recognize that tackling adult smoking and 'denormalising' smoking in the adult world is the best way to tackle youth smoking.

The tobacco companies have tried to exploit this paradox and have jumped on the youth anti-smoking bandwagon – but internal documents suggest this has been done for public relations reasons, to prevent the progress of measures to reduce adult smoking, and in the knowledge that it would make little difference to young people.

The RCP advocated government action in the following seven areas:

1. Public education

(i) more education of the public and especially school-children concerning the hazards of smoking:

Until 1998, relatively derisory sums had been spent on anti-tobacco education campaigns in comparison to the scale of the problem. By the 1990s it had become clear that the problem was not so much 'education' but 'motivation'. The challenge was to use messages that were powerful and even distressing, with enough media weight to change behaviour – using the principles of advertising

rather than teaching. The 1998 tobacco white paper, Smoking Kills, introduced at least £50 million over three years for education. However, this campaign has suffered from three main defects:

1. The amount spent is about £8 million less than committed
2. The money spent has been dissipated over too many small initiatives
3. Many of the mass media messages have been weak or incoherent

The spending on tobacco advertising is about eight times greater than the education budget, and we are spending about one-third of the amount per capita as California.

2. Restrictions on sales to minors

(ii) more effective restrictions on the sale of tobacco to children:

It has been an offence to sell cigarettes to under-16s for many years. However, enforcement has been left to the discretion of local authorities – the law simply requires that each local authority has a plan, even if the plan is to do nothing much. Many trading standards officers have worked hard to stop unscrupulous retailers selling to children, but that has not stopped teenage smoking. The value of cigarettes sold to under-16s is about 2000 times the level of fines imposed on retailers and the Treasury collects over £100 million in tax annually from cigarettes sold to under-16s.

It is difficult to deny access to cigarettes to under-16s – teenagers have proved remarkably resourceful in overcoming adult-imposed restrictions. The most promising approach is to try to reduce the demand and desire of young people to smoke. Supply-side measures are necessary, but definitely not sufficient.

3. Tobacco advertising

(iii) restriction of tobacco advertising:

Action was taken to ban cigarette advertising on television within three years of the 1962 report. But the response of the tobacco companies was to invest in sponsorship of televised sport – thus reducing their costs, qualitatively

changing their visibility and achieving a presence on the otherwise ad-free BBC. This is an example of the 'balloon theory' of tobacco advertising: place a partial restriction on tobacco advertising, and it is like pressing down on a balloon full of money – it simply bulges somewhere else, often with the benefit of added stimulus to creativity. It follows that the only effective approach is a comprehensive ban on all forms of tobacco advertising, promotion and sponsorship.

After years of inadequate half-measures that served the tobacco industry better than the public, the government elected in 1997 accepted this argument and recognised the failure of the voluntary agreements between government and tobacco industry since the 1980s. A near-complete ban on tobacco advertising was a manifesto commitment in 1997 and 2001. However, the present administration caused consternation when it failed to include a tobacco-advertising ban in the Queen's speech after the June 2001 election. The advertising legislation should be introduced as quickly as possible – and the ban on tobacco advertising globalised through the European Union and WHO Framework Convention on Tobacco Control.

4. Smoking in public places

(iv) wider restriction of smoking in public places:

In many respects this has been a private sector success but government failure. Public smoking is no longer ubiquitous and smoking is banned by the operators of many workplaces, public places and on almost all public transport. However, in 1999 three million non-smokers reported that they were frequently or continuously exposed to passive smoking while at work. The government has not taken the simple important step of making a smoke-free workplace a right, even where it is reasonably practicable to do it. The failure to accept the Approved Code of Practice on Passive Smoking at Work (ACoP) proposed in the tobacco white paper and endorsed by the multi-sectoral Health and Safety Commission represents the biggest failure of tobacco policy to date (at least there is a commitment to ban tobacco advertising!).

The voluntary Public Places Charter shows just how far there is to go in the hospitality sector. Three years after the PPC was announced, just 27% of establishments complied. Of those 20% opted for the 'smoking all areas' option

– also known as the 'do nothing' option. The Charter allows establishments to comply by doing nothing but simply placing a sign on the premises.

There should be a rapid agreement to the ACoP and targets set for improvements in smoking status through the Public Places Charter – backed by legislation if targets are not met.

5. Taxation

(v) an increase of tax on cigarettes, perhaps with adjustment of the tax on pipe and cigar tobaccos:

Taxation has increased substantially, but 'affordability' (minutes of average worker's time required to purchase a pack) of cigarettes is not greatly different from the 1960s. It is clear that real prices do affect consumption (a price elasticity of – 0.4 is often quoted meaning a 10% increase in real price causes a 4% reduction in demand). However, despite steep headline tax increases through the 1990s, it is not clear that actual prices paid have on average increased very much. Smokers have traded down, switched to hand-rolling tobacco and turned to the black market. Public health strategy now concentrates on raising the actual price paid, while maximising the opportunities for smokers to avoid the tax by quitting.

6. Consumer information

(vi) informing purchasers of the tar and nicotine content of the smoke of cigarettes:

The aim of providing consumer information remains a priority for legislators. The question is what would be meaningful consumer information? The use of machine-measured tar and nicotine yields is now discredited in the light of the proper understanding of nicotine addiction and smoking behaviour that has emerged since the 1980s. Smokers largely control their own nicotine intake to achieve a desired blood-nicotine level and when cigarettes have low readings on smoking machines, the smoker subconsciously 'compensates' by taking deeper puffs, more puffs or smoking more of the tobacco rod.

The advice of the College's 1962 report was elaborated in the 2000 report on nicotine addiction, which endorsed the principle of providing consumers with risk information, but rejected the system of machine-measured yields for doing it. The report concluded:

2. Tobacco product regulation is greatly complicated by the influence of nicotine on smoking behaviour. Current approaches to characterising the tar and nicotine yield of tobacco products are simplistic and misleading to consumers and regulators alike, and should be abandoned. This approach should be replaced with measurements and metrics that properly reflect the relative harm caused by different tobacco products, and by measures to ensure that this information is appropriately provided to consumers.

The system of machine measurement still holds the attention of legislators despite decades of scientific advance and clear understanding of its shortcomings. Regulation of tar and nicotine yield and printing of these on packs formed part of the 2001 European Union directive on product regulation (2001/37/EC). On the positive side, the directive increased health warnings to over one-third of the main pack faces (from September 2002) and banned misleading 'light' branding (effective from September 2003).

Smoking cessation

(vii) investigating the value of anti-smoking clinics to help those who find difficulty in giving up smoking.

It has taken many years to bring smoking cessation into the mainstream of the NHS – a process that only began in earnest in 1999 and remains far from complete. Previous governments blacklisted smoking cessation drugs and paid lip service to NHS engagement in smoking, apparently reasoning that this is a private matter and that if people can afford to smoke, then they can afford the treatments – an approach wholly discredited then, as now. The current government at last has provided £20 million per year for a network of smoking cessation clinics in each health authority and since 2000 has made smoking cessation drugs available through NHS prescriptions. Despite being among the most cost-effective expenditures made anywhere in the NHS, these services have been subject to uncertainty and apparent indifference from ministers.

The aim must be to see smoking cessation as a comprehensive programme designed to produce good health outcomes at low cost, while relieving the NHS of the burden of avoidable cancer, heart disease, and COPD.

Conclusion

The 1962 Royal College of Physicians report was a seminal contribution to public health in the UK. Its basic analysis of the aetiology of smoking-related disease remains unchallenged, though greatly elaborated. The changes in smoking prevalence since 1962 have saved about 1.6 million lives, but over five million have died as a result of their smoking – a toll that continues to mount as smoking continues at unacceptably high rates in Britain.

The policy proposals of the 1962 report remain valid today – though subject to update in the light of intervening scientific advance and programme experience. What is so shocking is that despite the College's call for urgency in 1962, the public policy agenda set out then remains substantially unfulfilled today.

Even today, the College continues to press for many of the same measures and propose tobacco policy as a radical approach to health inequalities and modernisation of the NHS. The accompanying letter, shows the approach the College takes to tobacco policy today. By taking available measures and spending on smoking cessation and mass-media the government should strive to achieve tougher targets – aiming for a one per cent reduction in smoking prevalence per year, rather than one percent every two and a half years.

The Way Forward

ROYAL COLLEGE OF PHYSICIANS

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22 January 2002

Dear Derek

Re: Public health and tobacco policy as part of NHS modernisation

In addition to the RCP's priorities and concerns about the modernisation of the NHS I have already discussed with you and your team, I would like to submit some brief written evidence on tobacco issues.

This year marks the 40th anniversary of the publication of the College's major report on smoking and health. Tobacco is still by far our greatest threat to public health, and the policy recommendations in that report aimed at reducing tobacco use are just as valid today, yet many have still not been implemented.

There has, of course, been great progress since the 1960s in reducing smoking prevalence, and the NHS is today reaping the rewards of those efforts in terms of reduced cancer, CHD and respiratory illness. If we can build more primary prevention into the reform of the NHS, then we can build on those gains.

The case for a radical and sustained approach to tobacco is clear. It is obviously better for both the patient and the NHS to spend a given sum on avoiding disease than treating it. We know that smoking cessation is extraordinarily cost-effective compared to almost everything else the NHS does. That begs the question - why we do not do more of it? We noted the very high projected spend on statins described in the interim report – smoking cessation is a far cheaper way to reduce CHD risk (and many other risks) and would be effective for 80% of patients currently taking statins. Achieving an appropriate balancing of resources between smoking cessation and statins expenditure would be a good case study in the use of cost-effectiveness data in modernising the NHS.

The College would like to see a far-reaching and committed approach to tobacco policy emphasised in your final report. Specifically, this could include:

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Interventions that help motivated smokers to quit– for example:

- Long-term commitment to stabilise and expand the established smoking cessation services to meet far more challenging targets (up to four times the current target);
- Inclusion of obligations to make regular and brief smoking cessation interventions in GP contracts;
- The development of a smoking cessation service in every hospital.
- The inclusion of smoking cessation in other settings – for example, ante-natal services, social services, prisons, educational institutions.
- Integration of smoking into medical training at all levels – the College is already active in rising to this challenge.

Interventions that motivate smokers to quit – for example:

- Substantial spending on a powerful mass media-based education campaign
- Increased provision of smoke-free environments at work and in public places - Government inaction in this area has been a conspicuous failure of the commitment made in its tobacco White Paper.
- Proper risk communication on packs
- Continuing use of tax policy (combined with measures to control of smuggling) to apply price incentives to quit.

Interventions that reduce the motivation to smoke– for example;

- Banning all forms of tobacco advertising, sponsorship and promotion – nationally and internationally. We were, as you already know, deeply and openly disappointed by the omission of the tobacco advertising legislation from the Queen's speech, an omission which also disappointed our Fellows and Members coping with tobacco-related illnesses at ward level. We hope that the Government will continue its quiet support for Lord Clement Jones' private members bill to ban tobacco advertising and do what it can to push the legislation through
- The use of bold, bleak warnings to communicate risk – and to reduce the attractiveness of cigarette packs.
- Elimination of misleading reassurance to smokers – such as 'light' branding and disproportionate claims of reduced harm in novel tobacco products.
- Control of additives and other manufacturing techniques that may make tobacco products more addictive or easier to learn to use.

Overall, this effort could be far better funded. The tax revenue from tobacco amounts to over £9 billion, yet the tobacco White Paper voted £37 million per year to tobacco policy – about 4 pence in every £10. I think it would be fair to return rather more than that directly to smokers as an investment in their health and long-term wellbeing.

I do hope these views are of interest and that efforts to tackle tobacco are receiving some prominence in your final report.

Yours sincerely

PROFESSOR SIR GEORGE ALBERTI, PRCP

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