
Foreword

As we approach the end of the 20th century, smoking continues to decline in the United States, with fewer than 1 in 4 adults reporting they use cigarettes on a regular basis. Per capita cigarette consumption currently stands at a level not seen since the early 1940s, and total consumption of cigarettes declined by 140 billion units in the past decade alone.

This stands in sharp contrast to the midpoint of the century when smoking rates were increasing, especially among women, and per capita cigarette consumption did not reach its peak until 1963, the year preceding publication of the first Surgeon General's report. Like America in 1950, cigarette manufacturers were enjoying unparalleled success and showing no sign of weakening. Then the cigarettes of choice were not the Marlboro, Winston, and Salems of today, but unfiltered Camels, Lucky Strike, Chesterfield, and Philip Morris. These four brands accounted for more than 75 percent of all brands sold in the United States. Camels, which had battled with Luckies for the top spot in the U.S. market for decades, had regained that position in 1949 and in 1950 had a 27-percent market share, leading Lucky Strike's 23 percent. Marlboro, the top-selling cigarette brand among the current generation of smokers with a 25 percent market share, had less than one-half of one percent.

At the beginning of the 1950s, the practice of cigarette smoking enjoyed nearly universal acceptance and widespread social appeal, not only in this country but also in many other parts of the world. Cigarette smoking was practiced by a substantial majority of adult males, with some age groups experiencing 70 to 75 percent smoking rates. Regular use of pipes and cigars was also common among men. The prevalence of smoking among physicians and dentists was equal to and even exceeded that seen in the general male population, whereas today less than 10 percent of physicians or dentists report themselves as cigarette smokers.

Smoking among women still lagged behind that of men, but by the mid-1950s nearly 3 of every 10 women reported they smoked cigarettes regularly. Just a few decades earlier women had been openly criticized for smoking, especially in public. However, by the end of the second world war, major social and environmental change that affected women's lifestyle choices, including smoking, had already begun. These changes, fueled by aggressive cigarette advertising and marketing, led to a rapid rise in the number of women smoking. By the end of the 1950s, smoking by women became not only socially acceptable but the expected norm among some strata of women.

It is useful to examine some of the processes by which the cigarette manufacturers were able to produce this widespread social acceptance and high level of cigarette use, and particularly for the purposes of this monograph, it is enlightening to examine how the credibility of physicians, dentists, and other health personnel was used to create a positive image for cigarette smoking. The reassuring image of physicians and other health care practitioners was used

extensively to convince the public that cigarette smoking was safe, acceptable, and without risk.

The growing public recognition of scientific methods was used to convince the consumer that smoking was healthy and to create confusion about the scientific certainty with which smoking had been established as a cause of disease. Both the health care and scientific communities were slow to recognize and respond to the cigarette manufacturers' use of their credibility to aid in the sale of cigarettes, and we therefore carry a special burden of responsibility in dealing with what is currently our largest preventible cause of death and disability.

The same authority and credibility that was used by cigarette manufacturers to sell cigarettes must now be applied by the health care community to reduce and eliminate the damage caused by tobacco in our society. This monograph is intended to present a comprehensive picture of what physicians, dentists, and other health care providers can do for their patients and communities to eliminate the needless disease and suffering produced by tobacco use. It is also a call to arms so that they can understand and combat the misuse of science and health imagery in the promotion of tobacco.

**USE OF HEALTH
THEMES AND
MEDICAL PERSONNEL
IN CIGARETTE
ADVERTISING**

The first modern blended U.S. cigarette—Camels—was introduced in 1913. Accompanying this change in manufacturing technique was the application of newly developed mass marketing approaches and advertising campaigns that relied heavily on health themes to promote cigarette consumption.

During the period from the mid-1920s through the end of the 1950s, all the major cigarette manufacturers in the United States used health-based themes in their advertising. These themes usually consisted of one or more of the following concepts:

- direct health claims—wherein a particular brand of cigarettes was promoted as having a “desirable” health benefit compared with competitors;
- images of health professionals—using models of physicians, dentists, or nurses, they were often used in conjunction with ads purporting a health benefit; and
- medical statements and testimonials—usually quoting scientists or doctors or citing information from surveys of health professionals or Government reports in an effort to minimize the perceived health risks of smoking or to imply that smoking a specific brand of cigarettes was safe or safer than other brands.

**WHEN HEALTH
BECAME AN ISSUE**

During the late 1920s and early 1930s, health themes began to appear increasingly in cigarette advertisements. As early as 1927, Lucky Strike was claiming that dangerous irritants in tobacco should be removed through heating. “It’s toasted” was a slogan used for years in all Lucky Strike ads. “Toasting,” according to these ads, removed “tobacco’s

harmful corrosive ACRIDS.” One ad in this series even asserted that the dangerous irritants removed from Lucky Strike tobaccos were sold to chemical companies.

Camels stressed how they “increase your flow of energy,” and famous athletes affirmed that Camels “don’t get your wind . . . you can smoke all you want!” Old Gold cigarettes promised “not a cough in a carload,” and Philip Morris instructed the smoker, “Sure you inhale, so play safe with your throat . . . scientifically proved less irritating . . .”

Perhaps one of the most notorious cigarette ad campaigns ever began in 1928 with Lucky Strike’s “Reach for a Lucky Instead of a Sweet.” Designed especially to entice women into the smoking ranks, this ad theme and its variations ran for several years and often featured well-known entertainers or sports figures attesting to the fact that Luckies kept them slim and petite. Even today, many cigarette ads promote the concept that smoking helps control weight—thus implying a health benefit. Brands such as “Virginia Slims” and “Superslims” directly

foster this concept and are marketed exclusively as female brands.



Some ads were obviously intended to convince both smokers and would-be smokers that not only was smoking safe, it was possibly even good for you. In many such advertisements, models portraying physicians, nurses, or scientists were prominently displayed.



We know today that such health claims were not grounded in science but were fabricated by Madison Avenue in a direct attempt to calm people’s growing fears about the dangers of smoking.

The Filtered Fifties The publication in the early 1950s of the first retrospective and prospective studies to conclusively link smoking with lung



cancer led to a new barrage of health claims and medical “testimonials” based on the cigarette industry’s newest technological “breakthrough”—the filtered cigarette.

Filter cigarettes were not entirely new, however, but merely a variation of an existing concept, the “tipped” or “mouthpiece” cigarette. Even prior to 1900 filter cigarettes such as Obak and Imperiale were marketed in this country from Europe, but the first major U.S. development in this field occurred in 1931 when Benson and Hedges introduced Parliament filter cigarettes. Viceroy brand cigarettes, marketed 5 years later, originally contained a hollow cotton tube and changed to a cellulose acetate filter in 1954. As the first such company to use cellulose, Brown and Williamson made the point of promoting the “20,000 individual filters in every Viceroy tip.” Cellulose acetate became the industry standard for filter cigarettes and is used to this day. Kool cigarettes came with a cork-tipped mouthpiece, whereas

Marlboro, initially promoted as a cigarette for women, came with a choice of ivory tips and beauty tips (in red) in addition to their “plain end.” Until health became an issue, however, no brand of tipped or filtered cigarettes ever enjoyed much popular or commercial success.

Filter cigarettes soon became the “new” technology that the manufacturers exploited to reassure smokers that regardless of any bad things in cigarettes, “science” now had a solution. At the same time that medical science was increasingly implicating smoking as a health threat, cigarette advertising extolled filter cigarettes as the scientific answer to the health “question.” In addition to print advertising, the companies increasingly used the new medium of television to promote these new cigarette product lines as safe. Even popular television shows such as the “Ben Casey, M.D.” and “Dr. Kildare” medical dramas were brought into millions of homes each week via cigarette sponsorship—and health protection was a commonly implied theme.



What can be labeled the greatest health fraud in cigarette history occurred in March 1952, when Lorillard Tobacco Company introduced Kent cigarettes with its new

“Micronite filter” that was “developed by researchers in atomic energy plants.” Lorillard ad copy stressed that the new filter removed seven times more tar and nicotine than any other brand. To bolster its claim, Lorillard cited none other than the *Journal of the American Medical Association* as its source.

After strenuous objections from the AMA, Kent discontinued any direct reference to that organization but continued to picture health professionals and used the “health protection” theme in both print and television ads for years, sometimes citing pseudoscientific test results in an effort to lend a degree of medical credibility to their claims.

Ironically, the substance in the Kent micronite filter that allegedly provided “health protection” turned out to be asbestos—one of the more dangerous occupational lung carcinogens known. Without any public disclosure whatsoever, the company quietly replaced the



asbestos with cellulose in 1957. Millions of smokers who had switched to Kents were never informed either that the filter had contained asbestos or that the asbestos had been replaced.



As the decade of the fifties drew to a close, filter cigarettes, virtually nonexistent at the beginning of the decade, had captured 50 percent of the U.S. market. This dramatic

change in brand market share provides indisputable evidence that cigarette advertising can alter consumer demand. A survey conducted by the Memorial Sloan-Kettering Cancer Center showed that 70 percent of smokers who switched from regular to filter-tipped cigarettes did so for reasons of health. Today, nearly 98 percent of all cigarettes sold in the United States are filtered.

Some Health Themes in Contemporary Advertising

Health claims in advertising did not end with the 1950s but continued well after the Surgeon General issued his now-famous 1964 report. By the beginning of the 1960s, the scientific consensus on the health consequences of smoking was overwhelming, and use of health professionals in cigarette ads could no longer be justified. Nonetheless, health themes are evident even in today’s cigarette advertisements.



GAS IN CIGARETTE SMOKE MAY BE A BIGGER PROBLEM THAN TAR AND NICOTINE, AMERICAN MEDICAL ASS'N TOLD

San Francisco, June 19: (As reported by major newspapers and wire services) The A.M.A. Convention was told by an important medical researcher from one of the major U.S. universities that the real problem may be in the gas content of cigarette smoke and not tar and nicotine.

ONLY LARK HAS THE GAS-TRAP FILTER

Lark's unique Gas-Trap Filter (U.S. Patent No. 3,251,365) reduces certain hot vapors by nearly twice as much as any other popular brand. This reduction of those gases gives Lark a smooth taste no other cigarette can imitate.

After the 1964 Surgeon General's report, the cigarette companies began citing official Government sources and statistics to promote some brands that were reportedly lower in tar and nicotine. Carlton cigarettes for years used Federal Trade Commission (FTC) test results to proclaim, "Latest U.S. Gov't Report Confirms Carlton is Lowest" or "U.S. Gov't Report: A whole carton of Carlton has less tar than a single pack of" Now cigarette ads stated, "Now is Lowest" in tar; Pall Mall Extra Mild used FTC data to compare its cigarette brand to others with "2800 mg tar a week you can lose . . . with Pall Mall Extra Mild." Later, it would be found that many cigarette brands had been purposefully engineered to test low in tar/nicotine content based on machine measurement but that they generated much higher yields when smoked by people.

U.S. GOV'T REPORT:

Carlton is lowest.

Lowest tar of all brands in machine tests for 100 mg. cigarettes.

Direct Attack on Smoking Health Risk Information

Earlier cigarette advertising was intended to create doubt among smokers and would-be smokers regarding the "alleged" association between smoking and health, but a series of R.J. Reynolds ads in 1984 took a more direct approach. Published in national news magazines, Reynolds emphatically stated that "studies which conclude that smoking causes disease have regularly ignored significant evidence to the contrary." This statement was made 30 years after the publication of numerous studies linking smoking to lung cancer and other diseases and 20 years after the Surgeon General's report provided a clear scientific

Can we have an open debate about smoking?

The most basic principle of democracy is the right of every citizen to an open debate on the issues that affect his or her life.

But for the past 30 years, the cigarette industry has been engaged in a campaign to prevent such a debate. It has done this by attacking the scientific studies that link smoking to disease and by attacking the Surgeon General's report. It has done this by attacking the Surgeon General's report. It has done this by attacking the Surgeon General's report.

It is time to have an open debate about smoking. It is time to have an open debate about smoking. It is time to have an open debate about smoking.

R.J. Reynolds Tobacco Company

consensus that “Cigarette smoking is a health hazard of sufficient importance in the United States to warrant appropriate remedial action.”

In a followup ad, Reynolds even boasts, “We believe in science. That is why we continue to provide funding for independent research into smoking and health.”

It is difficult to determine exactly what effect such ads have on the public. At the very least, they serve to create doubt in some smokers’ mind about whether the link between smoking and health is real, especially among those individuals who are considering quitting and who may delay taking action that could benefit their health. However, there is no question that these ads are a deliberate misrepresentation of the scientific knowledge of the disease risks associated with cigarette smoking.



Tobacco and The Clinician This monograph provides important information on how health care professionals can contribute to the national effort to reduce smoking both among individual patients and in our communities. Health professionals have a responsibility to ensure that the 50 million people who continue to smoke fully understand the true health consequences of their behavior, and where appropriate, the health professional should provide direct assistance to help them become nonsmokers.

Equally important, we need to become smoking experts within our communities to counter tobacco industry-sponsored misrepresentation of scientific fact. Whether it is providing justification for policies protecting nonsmokers from the harm caused by passive smoking, preventing underage youth from having easy access to tobacco, or restricting certain types of cigarette promotions, health professionals need to acquire the skills necessary to effectively address these issues. After all, if we don’t, who will?

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