



**Submission of the
British Medical Association to the
Health Committee Enquiry into the
Tobacco Industry**

14 October 1999

BMA Submission to the Health Select Committee Enquiry into the Tobacco Industry

The British Medical Association – the voice of Britain’s doctors

The British Medical Association is the voice of the medical profession in the UK. With a membership of more than 120 000, the BMA represents more than 80% of British doctors. Every day, Britain’s doctors come face to face with the suffering and death caused by smoking. In the UK, smoking accounts for more than 120 000 deaths each year – about one in every five deaths. In England alone, it has been estimated that annually, around 284 000 admissions to NHS hospitals, 8 million GP consultations and 7 million prescriptions are the result of a smoking-related illness¹. The evidence of the BMA to the Committee reflects its members’ concern for their patients, their responsibilities to the health of the nation, and their duties as public servants.

Scientific knowledge of the harmful health effects of smoking and of the nature of nicotine

More than 70,000 scientific papers and reports have been published on the adverse health effects of smoking². Landmarks in the evolution of early scientific knowledge of the health effects of smoking are outlined in Appendix 1. Beginning in the 1960s, a series of authoritative reports have *assessed and evaluated* the scientific evidence that smoking causes disease, notably:

- 1962 – Royal College of Physicians of London concludes that smoking causes lung cancer and bronchitis and probably contributes to coronary heart disease³
- 1964 – US Surgeon General’s Report concludes that smoking causes lung and laryngeal cancer and chronic bronchitis⁴
- 1971 – Royal College of Physicians of London concludes that ‘if women ...smoke the way men do, their death rate is likely to become the same’⁵
- 1977 – Royal College of Physicians of London concludes that tobacco smoking is a form of drug dependence and that nicotine is probably the addictive substance involved⁶
- 1983 – UK Independent Scientific Committee on Smoking and Health concludes that smoking during pregnancy retards foetal growth⁷
- 1986 – US Surgeon General’s Report concludes that nicotine addiction plays a central physiological role in smoking⁸
- 1988 – UK Independent Scientific Committee on Smoking and Health concludes that passive smoking causes lung cancer⁹
- 1992 – US Environmental Protection Agency Report concludes that passive smoking causes cancer and heart disease¹⁰
- 1998 – UK SCOTH Report concludes that smoking is the most important cause of premature death in developed countries and accounts for one fifth of all deaths in the UK¹¹
- 1999 – WHO expert consultation concludes that passive smoking causes respiratory disease and middle-ear infection, and reduces lung growth and function in children¹²

¹ Godfrey C, Raw M, Sutton M, Edwards H. The smoking epidemic - a prescription for change. London: Health Education Authority, 1993.

² WHO. Combating the Tobacco Epidemic. In: The World Health Report 1999. Geneva, World Health Organization, 1999. Available online at: <http://www.who.int/toh/>

³ Royal College of Physicians of London. Smoking and Health. London: Pitman Medical, 1962.

⁴ US DHSS, Smoking and Health: Report of the Advisory Committee to the Surgeon General of the Public Health Service. US Department of Health and Human Services, 1964.

⁵ Royal College of Physicians of London. Smoking and Health Now. London: Pitman Medical, 1971.

⁶ Royal College of Physicians of London. Smoking or Health. London: Pitman Medical, 1977.

⁷ Independent Scientific Committee on Smoking and Health: Third Report. London: Her Majesty’s Stationery Office, 1983.

⁸ US DHHS. The Health Consequences of Smoking: Nicotine Addiction. A Report of the Surgeon General. US Department of Health and Human Services, 1988.

⁹ Independent Scientific Committee on Smoking and Health: Fourth Report. London: Her Majesty’s Stationery Office, 1988.

¹⁰ US EPA. Respiratory Health Effects of Passive Smoking: Lung Cancers and other Disorders. US Environmental Protection Agency, 1992. Available online at: <http://www.epa.gov/ncea/smoking.htm>

¹¹ UK Department of Health. Report of the Scientific Committee on Tobacco and Health. London: Her Majesty’s Stationery Office, 1998.

Appendix 2 summarizes selected recommendations by UK expert committees from 1962–1998.

Active smoking is the major cause of lung cancer, chronic bronchitis and emphysema and a major cause of heart disease and stroke. It is also causes or contributes to a plethora of other illnesses¹³. A breakdown of the death toll from smoking-induced disease in the UK is given in Appendix 3.

Passive smoking has been established as a cause of heart disease¹⁴ and of lung cancer¹⁵ in adults. In children, passive smoking is known to cause lower respiratory illness, reduced lung growth and middle ear disease. In addition, second-hand smoke can cause asthma, and increases the severity of the condition in children who are already affected¹⁶.

Nicotine is a psychoactive substance that occurs naturally in tobacco. Nicotine affects the brain, heart and endocrine system, quickening the heart rate, increasing blood pressure, and narrowing blood vessels.

Nicotine is highly addictive. Tobacco dependency is recognised as a behavioural disorder in the World Health Organisation International Classification of Diseases¹⁷. Habitual use of nicotine through smoking meets the key medical criteria for drug dependence, including psychoactive effects, compulsive use and self-reinforcing behaviour. Smokers experience a withdrawal syndrome when they abstain from tobacco¹⁸.

Nicotine addiction can rapidly become established after initiation of tobacco use¹⁹. As the SCOTH report concluded: 'addiction to nicotine sustains cigarette smoking and is responsible for the remarkable intractability of smoking behaviour'²⁰. Addiction to nicotine therefore increases the smoker's vulnerability to the harm caused by long-term exposure to tobacco smoke.

Tobacco industry response

The results of the body of independent scientific work on the adverse health effects of tobacco are in the public domain. They have been, and continue to be, available to the tobacco industry. In addition, the industry has had privileged access to the results of its own research programmes and of certain other research studies it has funded. Internal documents released during legal action in the United States of America reveal that an industry-wide effort sought to create and maintain doubts about the harmful effects of tobacco. Misinformation campaigns were conducted with a view to protecting against liability actions brought by customers whose health had been damaged by smoking, avoiding government regulation, and maximizing profits by maintaining product sales²¹.

The industry conducted extensive internal research into the health effects of smoking, including analysis of cigarette smoke, identification and characterization of cancer-inducing and tumour-promoting components, and the elucidation of the effects of smoking in animal models and in human subjects. For the most part, the results of these studies remained secret. Moreover, while publicly criticizing the scientific tests being used by independent scientists in studies demonstrating the link between smoking and cancer, the industry was using these same tests to assess the mutagenic and carcinogenic effects of cigarettes. Despite the high quality of much of this research, very few of these studies were published in the scientific literature²².

¹² International Consultation on Environmental Tobacco Smoke and Child Health: Consultation Report. Geneva: World Health Organization, 1999. WHO/NCD/TFI/99.10. Online version available at: <http://www.who.int/toh/consult.htm>

¹³ UK Department of Health. Report of the Scientific Committee on Tobacco and Health. London: Her Majesty's Stationery Office, 1998.

¹⁴ Law MR, Morris JK, Wald NJ. Environmental tobacco smoke and ischaemic heart disease: an evaluation of the evidence. *BMJ* 1997;315:973-79. Available online at: <http://www.bmj.com/cgi/content/full/315/7114/973>

¹⁵ Hackshaw AK, Law MR, Wald NJ. The accumulated evidence on lung cancer and environmental tobacco smoke. *BMJ* 1997;315:980-89. Available online at: <http://www.bmj.com/cgi/content/full/315/7114/980>

¹⁶ International Consultation on Environmental Tobacco Smoke and Child Health. Consultation Report. World Health Organization, 1999. WHO/NCD/TFI/99.10. Online version available at URL: <http://www.who.int/toh/consult.htm>

¹⁷ International Classification of Disease, 10th revision (ICD-10). Geneva: World Health Organization, 1975.

¹⁸ US DHHS. The Health Consequences of Smoking: Nicotine Addiction. A Report of the Surgeon General. US Department of Health and Human Services, 1988.

¹⁹ McNeill AD. The development of dependence on smoking in children. *Br J Addiction* 1991;86:589-92

²⁰ UK Department of Health. Report of the Scientific Committee on Tobacco and Health. Her Majesty's Stationery Office, 1998.

²¹ Looking through a Keyhole at the Tobacco Industry. In: Glantz SA, Slade J, Bero LA, Hanauer P, Barnes DE. The Cigarette Papers. Berkeley, CA: University of California Press, 1996. Online version available at URL: <http://www.library.ucsf.edu/tobacco/cigpapers/book/chapter1/5.html>

²² Hanauer P, et al. Lawyer control of internal scientific research to protect against products liability lawsuits. The Brown and Williamson documents. *JAMA* 1995; 274(3):234-40

The early response of the industry included a private research programme to investigate the possibility of producing a 'safe' cigarette²³. A certain degree of progress appears to have been made in identifying additives that might reduce the carcinogenicity of cigarettes²⁴. Ultimately, however, concerns that marketing a 'safe' cigarette would amount to an admission of the dangers of the existing product came to dominate, and research in this area was all but abandoned²⁵.

Through front groups such as the Tobacco Industry Research Council, the industry sponsored studies by external scientists. In public, the industry maintained that the primary aim of this research was to help resolve the 'controversy' surrounding tobacco and health. In private, however, the industry-sponsored research was directed with an eye to reducing the likelihood of future liability actions. Company lawyers were intimately involved in controlling industry-sponsored studies, vetoing the research agenda, drafting and approving study reports, and deciding which projects would be funded or discontinued²⁶.

An extensive industry research programme investigated the effects of nicotine in animals and in humans. Industry scientists and executives understood the essentially addictive nature of their product, and emphasized the key importance of nicotine in selling tobacco²⁷.

The tobacco industry developed technologies to allow it to control the level of nicotine in tobacco and to modify the amount of nicotine absorbed by the smoker. Patents filed in the USA document processes by which nicotine can be removed from tobacco or added to cigarettes, by spraying on tobacco, on filters or on cigarette paper²⁸.

Consumer protection

Given the weight of the scientific evidence and the scale of the suffering caused by smoking, a responsible industry would be expected to act to protect the health of its consumers. However, with regard to consumer protection, the response of the tobacco industry has been singularly inadequate. Throughout the course of the tobacco epidemic, the industry has failed in its responsibilities on numerous counts:

Failure to fully inform of the dangers of smoking

Active smoking. The record shows that while publicly denying the harmful effects of its product, the tobacco industry has been well aware of its hazards. Only recently has the tobacco industry admitted the fact that active smoking harms health. However, these admissions continue to be couched in terms that owe more to concerns of liability than to consumer welfare, and fail to address the true nature and magnitude of the health effects of smoking.

Passive smoking. The tobacco industry has yet to admit that passive smoking causes illness. Industry-wide studies on the health effects of passive smoking have been underway since the 1960s, and privately, the industry has accepted the validity of independent studies on the harmful effects of passive smoking²⁹. Publicly, the same tactics used in creating a false controversy around the harmful effects of active smoking are now being used to attempt to discredit scientific knowledge of the harms caused by passive smoking.

Nicotine addiction. The tobacco industry has not accepted that nicotine is addictive. Rather, setting aside the compelling evidence that the effects of nicotine on the brain are similar to those of drugs such as heroin and

²³ Smoking and Disease: The Tobacco Industry's Earliest Responses. In: Glantz SA, Slade J, Bero LA, Hanauer P, Barnes DE. The Cigarette Papers. Berkeley, CA: University of California Press, 1996. Online version available at URL: <http://www.library.ucsf.edu/tobacco/cigpapers/book/chapter2/8.html>

²⁴ Agricultural Chemicals and Cigarettes. In: Glantz SA, Slade J, Bero LA, Hanauer P, Barnes DE. The Cigarette Papers. Berkeley, CA: University of California Press, 1996. Online version available at URL: <http://www.library.ucsf.edu/tobacco/cigpapers/book/chapter6/3.html>

²⁵ The Search for a 'Safe' Cigarette In: Glantz SA, Slade J, Bero LA, Hanauer P, Barnes DE. The Cigarette Papers. Berkeley, CA: University of California Press, 1996. Online version available at URL: <http://www.library.ucsf.edu/tobacco/cigpapers/book/chapter4/10.html>

²⁶ Bero L, Barnes DE, Hanauer P, Slade J, Glantz SA. Lawyer control of the tobacco industry's external research program. The Brown and Williamson documents. *JAMA* 1995; 274(3):241-7

²⁷ Addiction and Cigarettes as Nicotine Delivery Devices. In: Glantz SA, Slade J, Bero LA, Hanauer P, Barnes DE. The Cigarette Papers. Berkeley, CA: University of California Press, 1996. Online version available at URL: <http://www.library.ucsf.edu/tobacco/cigpapers/book/chapter3/8.html>

²⁸ Kessler DA. Statement on nicotine-containing cigarettes. *Tob Control* 1994;3:148-158

²⁹ Environmental Tobacco Smoke and the Nonsmokers' Rights Movement. In: Glantz SA, Slade J, Bero LA, Hanauer P, Barnes DE. The Cigarette Papers. Berkeley, CA: University of California Press, 1996. Online version available at URL: <http://www.library.ucsf.edu/tobacco/cigpapers/book/chapter10/6.html>

cocaine³⁰, the industry trivializes the central physiological role of nicotine addiction in motivating smoking by comparing tobacco dependency to habits such as eating chocolate. The tobacco industry has consistently maintained that smoking is entirely a matter of 'free choice'.

Failure to reduce the harmfulness of their product

A less harmful cigarette? The record shows that industry research carried out into a 'safe' cigarette was not implemented because of fears of product liability actions. Instead, the industry has produced 'light' cigarettes, described as low in tar and nicotine. These products were developed in an effort to alleviate smoker's health concerns and marketed accordingly. However, it is clear that the stated yields of tar and nicotine on the packet bear little resemblance to those absorbed by the smoker³¹. The industry was well aware both that these cigarettes offered no real health benefits, and that marketing of 'light' cigarettes would 'actually retain some potential quitters in the cigarette market'³². Not only does the tobacco industry knowingly continue to market a product that seriously harms health, it exploits smokers' health concerns to protect company profits.

Nicotine and addiction. While the technology is available to reduce the nicotine content of cigarettes, an analysis by the USA FDA found that the levels of nicotine in cigarettes has increased rather than decreased. There is evidence that this has been made possible through the introduction of additives that increase the effective dose of nicotine delivered to the smoker, while having no effect on testing systems used by most regulatory authorities for ascertaining the levels of tar and nicotine displayed on cigarette packs³³. The industry has failed to act to protect its customers' health by removing nicotine from its product; rather, it has used the knowledge and technology available to enhance delivery of nicotine in its products.

Failure to disclose the content of their product

Cigarette smoke contains more than 4000 components, including many toxins, mutagens and carcinogens. The industry carried out extensive analyses of both mainstream (inhaled) and sidestream (second-hand) smoke; however, the results of this research were not made public. In addition, more than 600 substances are authorized for use in tobacco products³⁴. Additives can be used to modify cigarette smoke to make it more palatable and to increase the dose of nicotine that the smoker receives. The substances added may dilate the airways, increasing exposure to the harmful effects of tobacco smoke inhalation, and may numb the throat, making it easier for novice smokers to persist with experimentation. They may also reduce the visibility and smell of second-hand smoke. The tobacco industry has failed to disclose the additives used in particular products, as well as information on their toxicity and biological effects.

Failure to compensate for damage caused to consumer

It has been estimated that during the past 50 years, almost 6 million Britons have been killed by smoking. In developed countries, the death toll is around 60 million³⁵. Behind these statistics lie the enormous human suffering and distress caused by smoking-related illnesses, both fatal and non-fatal. Industry documents reveal that a central motivating factor in the response of the tobacco industry to scientific knowledge on the harmful effects of smoking has been the desire to evade product liability claims from individual consumers, health insurance companies and governments. While failing to fully inform the consumer of the true nature and risks of smoking, the tobacco industry has also failed to compensate those who suffer from smoking-induced illnesses as the result of using its product as intended.

³⁰ Pich EM, Pagliusi SR, Tessari M, Talabot-Ayer D, Hooft van Huijsduijnen R, Chiamulera C. Common neural substrates for the addictive properties of nicotine and cocaine. *Science* 1997;275:83-86

³¹ Bates C, Jarvis M. Low Tar: why low tar cigarettes don't work and how the tobacco industry fooled the smoking public. London: ASH, 1999. Online version available at: <http://www.ash.org.uk/papers/big-one.html>

³² Imperial Tobacco Ltd, 1978. Response of the market and of Imperial Tobacco to the smoking and health environment. Exhibit AG-41, RJR-Macdonald Inc. v Canada (Attorney General). Cited in: Cunningham R. *Smoke and Mirrors*. (p. 164) Ottawa, ON: International Development Research Centre, 1996.

³³ Kessler DA. The control and manipulation of nicotine in cigarettes. *Tob Control* 1994;3:362-69

³⁴ Bates C, Connolly GN, Jarvis M. *Tobacco Additives*. London: Action on Smoking and Health and The Imperial Cancer Research Fund, 1999.

³⁵ Peto R, Lopez AD, Boreham J, Thun M, Heath C. *Mortality from Smoking in Developed Countries 1950-2000*. Oxford: Oxford University Press, 1994.

Avoidance of regulation

The legitimate role of government in protecting the consumer and the public health includes effective regulation. Measures that have been proven to be effective in reducing the burden of avoidable disease and death from smoking and in protecting the individual from the harmful effects of smoking include effective taxation policies, bans on advertising and promotion of tobacco, and measures of the protection of non-smokers³⁶. While failing to publicly accept that these measures are effective in reducing tobacco consumption, the tobacco industry has consistently resisted and campaigned against their implementation.

Regulation of the tobacco industry in the UK has often been attempted through voluntary agreements with the industry. Adherence has been assessed by the Committee for Monitoring Agreements on Tobacco Advertising and Health, composed in equal part of representatives from the tobacco industry and independent assessors. Experience shows that the effectiveness of this mechanism is limited. The procedure relies on public complaints and allows infringements of the agreements to continue while a ruling is made. Moreover, no meaningful penalty is imposed on the industry when a complaint is upheld. The introduction of a legislative ban on tobacco promotion and advertising is welcome, placing as it does the burden on the tobacco industry to comply with measures to protect the public health. Future regulatory measures to prevent tobacco-induced illness and death should be framed with this experience in mind.

Failures of global responsibility

The British-based tobacco industry operates in a global market, and is among the largest transnational cigarette manufacturers. As tobacco consumption in the UK falls, British tobacco companies are increasingly looking to market opportunities elsewhere.

If current trends continue, the global death toll from tobacco will rise from about 4 million per year in 1998 to about 10 million per year in 2030. Over 70% of these deaths will occur in the developing world³⁷. In 1990, smoking accounted for one in six adult deaths; in 2020, it will account for one in three³⁸.

While scientific knowledge on the harmful effects of smoking is accepted internationally, public knowledge of the health risks of smoking varies worldwide. In 1991, health warnings were required by 70 countries³⁹. In the absence of warnings imposed by government, the tobacco industry fails to disclose even the most basic information on the health risks of smoking.

A recent report by the World Bank highlighted the economic losses associated with tobacco and concluded that an integrated strategy to address the global tobacco epidemic would include increasing taxes, adding prominent warning labels to cigarettes, adopting comprehensive bans on advertising and promotion, and restricting smoking in workplaces and public places⁴⁰.

International action is urgently needed to curb the global tobacco epidemic. The International Convention for Tobacco Control being developed by the World Health Organisation is an international legal instrument designed to protect the public health against the global spread of tobacco. We commend the support for the Convention expressed in the recent White Paper on Tobacco⁴¹, and urge the Government to facilitate its development and implementation.

³⁶ The World Bank. *Curbing the Epidemic: Governments and the Economics of Tobacco Control*. Development in Practise. Washington, DC: The World Bank, 1999. Online version available at: <http://www.who.int/toh/>

³⁷ WHO. *Combating the Tobacco Epidemic*. In: *The World Health Report 1999*. Geneva, World Health Organization, 1999. Available online at: <http://www.who.int/toh/>

³⁸ Murray CJL, Lopez AD. *The Global Burden of Disease*. Cambridge, MA: Harvard University Press, 1996.

³⁹ Roemer R. *Legislative Action to Combat the Tobacco Epidemic*. Geneva: World Health Organization, 1993.

⁴⁰ The World Bank. *Curbing the Epidemic: Governments and the Economics of Tobacco Control*. Development in Practise. Washington, DC: The World Bank, 1999. Online version available at: <http://www.who.int/toh/>

⁴¹ Department of Health. *Smoking Kills: A White Paper on Tobacco*. London: Her Majesty's Stationery Office, 1998. Available online at: <http://www.official-documents.co.uk/document/cm41/4177/4177.htm>

Appendix 1. Landmarks in the development of early scientific knowledge on smoking and health

- 1939** • Muller finds a statistical link between smoking and cancer in a small-scale study⁴²
- 1950** • Publication of three key large-scale epidemiological studies linking smoking to lung cancer, by Levin⁴³, Wynder and Graham⁴⁴, and Doll and Hill⁴⁵
- 1952** • Doll and Hill publish report concluding that ‘the association between smoking and carcinoma of the lung is real’⁴⁶
- 1953** • Wynder, Graham and Croninger show that cigarette tar painted on mice causes tumours⁴⁷
- 1954** • Doll and Hill publish preliminary results of their study of British doctors showing that smoking is associated with increased lung cancer and contributes to heart disease⁴⁸
- 1956** • Auerbach publishes the first in a series of reports showing that smoking induces precancerous changes in the lung, which increase with amount smoked and decline after smokers quit⁴⁹
 - Doll and Hill report that death rates from lung cancer among heavy smokers are 20 times those among nonsmokers, and that death rates decline in proportion to the length of time since stopping⁵⁰
- 1957** • The British Medical Research Council publishes a statement that there is ‘a direct causal connection’ between smoking and lung cancer⁵¹
 - US National Cancer Institute, US National Heart Institute, American Heart Association and American Cancer Society ad hoc study group concludes that the ‘sum total of scientific evidence establishes beyond reasonable doubt that cigarette smoking is a causative factor’ in lung cancer⁵²
 - US Surgeon-General states that prolonged smoking is a causative factor in aetiology of lung cancer⁵³
- 1958** • Hammond and Horn report that smoking causes both lung cancer and coronary artery disease⁵⁴ •
- 1959** • Dorn reports that smokers have a 58% higher death rate than nonsmokers, and that the earlier one starts to smoke, the poorer one’s health⁵⁵ •
- 1960** • World Health Organization reviews the available scientific evidence and concludes that smoking causes lung cancer⁵⁶ •
- 1962** • Royal College of Physicians reviews the evidence from some 200 epidemiological and biological studies and concludes that smoking is a cause of lung cancer and bronchitis, and probably contributes to coronary heart disease and other less common diseases⁵⁷

⁴² Muller FH. Tabakmissbrauch und lungencarcinoma *Zeitschrift fur Krebsforschung* 1943;54:261-9

⁴³ Levin ML, Goldstein H, Gerhardt PR. Cancer and tobacco smoking: a preliminary report. *JAMA* 1950;143:336-38

⁴⁴ Wynder EL, Graham EA. Tobacco smoking as a possible etiologic factor in bronchogenic carcinoma *JAMA* 1950;143:329-36

⁴⁵ Doll R, Hill AB. Smoking and carcinoma of the lung: preliminary report. *BMJ* 1950;143:329-36

⁴⁶ Doll R, Hill AB. A study of the aetiology of carcinoma of the lung *BMJ* 1952;1:1271-86

⁴⁷ Wynder EL, Graham EA, Croninger AB. Experimental production of carcinoma with cigarette tar. Part 1. *Cancer Res* 1953;13:855

⁴⁸ Doll R, Hill AB. The mortality of doctors in relation to their smoking habits: a preliminary report. *BMJ* 1954;1:1451-55

⁴⁹ Auerbach O et al. Changes in the bronchial epithelium in relation to smoking and cancer of the lung. *New Engl J Med* 1957;256:97

⁵⁰ Doll R, Hill AB. Lung cancer and other causes of death in relation to smoking. A second report on the mortality of British doctors. *BMJ* 1956;ii:1071

⁵¹ Medical Research Council. Tobacco smoking and cancer of the lung. Statement by the Medical Research Council. *BMJ* 1957;1:1523-4

⁵² US Study Group on Smoking and Health. Smoking and health. *Science* 1957; 125:1129

⁵³ Burney LE. Smoking and lung cancer. A statement of the Public Health Service. *JAMA*;1959:71,1829

⁵⁴ Hammond EC, Horn D. Smoking and death rates--report on forty-four months of follow-up of 187,783 men. Part II Death rates by cause. *JAMA* 1958; 166:1294.

⁵⁵ Dorn H. Tobacco consumption and mortality from cancer and other diseases. *US Publ Hlth Rep* 1959;74 (7):581

⁵⁶ World Health Organization. Epidemiology of cancer of the lung. Report of a study group. *WHO Tech Rep* 192.

⁵⁷ Royal College of Physicians of London. Smoking and Health. London: Pitman Medical, 1962.

Appendix 2. Selected recommendations by UK expert committees for action to protect the public health from tobacco, 1962–1998

- 1962** The Royal College of Physicians of Londonⁱ recommends action to ‘curb the present rising consumption of tobacco, and especially of cigarettes’, including:
- more effective public information
 - strengthening of regulations forbidding sales to children and sales from vending machines
 - restriction of tobacco advertising
 - organisation of smoking cessation clinics
 - disclosure of the constituents of tobacco smoke on cigarette packets
 - increases in tobacco taxation
- 1971** Royal College of Physicians of Londonⁱⁱ recommends action to ‘end the present holocaust’, including:
- more effective public information
 - strengthening of regulations forbidding sales to children and removal of vending machines from public places
 - prohibition of advertising and gift-coupon schemes
 - restriction of smoking in public places
 - development of more effective techniques to help smokers to quit
 - imposition of statutory limits on tar and nicotine levels in cigarettes
- 1977** Royal College of Physicians of Londonⁱⁱⁱ recommends steps ‘to reduce and ultimately prevent the harm now being done to people’s health by smoking of tobacco’, including:
- more effective public information
 - strengthening of regulations forbidding sales to children and removal of vending machines from public places
 - phasing out of tobacco promotion, including advertising, coupons and sponsorship
 - restrictions on smoking in public places
 - development of more effective techniques to help smokers to quit
 - limitation of tar and nicotine levels
 - increased taxation
- 1988** UK Independent Scientific Committee on Smoking and Health^{iv} recommends:
- more effective public information
 - restrictions on smoking in public places
 - consideration of all options to encourage more smokers to stop and to discourage nonsmokers from starting
- 1998** UK SCOTH Report^v recommends that ‘the Government should take effective action to limit this preventable epidemic’, including:
- more effective public information
 - a ban on all forms of tobacco advertising, promotion and identifiable sponsorship
 - measures to restrict smoking in public places
 - encouraging smoking cessation
 - increases in the real price of tobacco products

ⁱ Royal College of Physicians of London. Smoking and Health. London: Pitman Medical, 1962.

ⁱⁱ Royal College of Physicians of London. Smoking and Health Now. London: Pitman Medical, 1971.

ⁱⁱⁱ Royal College of Physicians of London. Smoking or Health. London: Pitman Medical, 1977.

^{iv} Independent Scientific Committee on Smoking and Health: Fourth Report. London: Her Majesty's Stationery Office, 1988

Appendix 3. Annual smoking-attributable deaths in the UK^v

Condition	Percentage of deaths from the condition attributable to smoking		Number of deaths from the condition attributable to smoking		
	Men	Women	Men	Women	TOTAL
CANCERS					
Lung	90	73	21 100	9 500	30 600
Throat & mouth	74	47	1 500	400	1 900
Oesophagus	71	62	2 900	1 600	4 500
Bladder	48	17	1 700	300	2 000
Kidney	41	5	700	100	800
Stomach	35	10	1 700	300	2 000
Pancreas	21	25	600	800	1 500
Unspecified site	34	7	2 400	500	3 000
Leukaemia	19	10	200	100	300
<i>Total</i>					<i>46 000</i>
HEART & CIRCULATION					
Ischaemic heart disease	23	11	18 700	7 600	26 400
Aortic aneurysm	62	48	4 000	1 800	5 800
Myocardial degeneration	24	10	300	300	600
Atherosclerosis	17	5	100	100	200
Stroke	13	9	3 400	3 900	7 300
<i>Total</i>					<i>40 300</i>
OTHERS					
Bronchitis & emphysema	86	79	15 100	9 300	24 400
Pneumonia	25	11	5 800	4 100	9 900
Ulcer of the stomach & duodenum	47	41	1000	1000	2000
TOTAL			81 300	41 700	123 000

^vUK Department of Health. Report of the Scientific Committee on Tobacco and Health. London: Her Majesty's Stationery Office, 1998.