

1999

The Influence of the Minnesota Tobacco Trial on the Healthcare Community and Tobacco Regulation

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Recommended Citation

Hurt, Richard D. (1999) "The Influence of the Minnesota Tobacco Trial on the Healthcare Community and Tobacco Regulation," *William Mitchell Law Review*: Vol. 25: Iss. 2, Article 9.

Available at: <http://open.mitchellhamline.edu/wmlr/vol25/iss2/9>

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THE INFLUENCE OF THE MINNESOTA TOBACCO TRIAL ON THE HEALTHCARE COMMUNITY AND TOBACCO REGULATION†

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I. THE MINNESOTA TOBACCO TRIAL	455
II. THE CIGARETTE – A TWENTIETH CENTURY EPIDEMIC.....	461
III. THE TOBACCO INDUSTRY’S POLITICAL INFLUENCE	462
IV. THE HEALTHCARE SYSTEM AND TOBACCO.....	464
V. WHAT CAN WE DO BETTER?	468

I. THE MINNESOTA TOBACCO TRIAL

The purpose of this article is to provide information on the current status of the healthcare community’s involvement in the tobacco and health issue and how we might better interface with the political and legal systems to help control the epidemic of tobacco-caused diseases.¹

The legacy of the trial, and the more than thirty-three million

† This essay is based on a speech Richard D. Hurt, M.D., gave at William Mitchell College of Law’s Center for Health Law & Policy symposium titled, “Tobacco Regulation: The Convergence of Law, Medicine & Public Health.”

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1. Before getting into the particulars of this issue, I want to acknowledge that my participation in the Minnesota tobacco trial (*State ex rel. Humphrey v. Philip Morris Inc.*, No. C1-94-8565 (Minn. Dist. Ct. May 8, 1998)) was one of the highlights of my career. Working with people like Michael Ciresi, Roberta Walburn, Gary Wilson, Susan Nelson, Tara Sutton, Corey Gordon, Roman Silberfeld, Michael Berens and many others was an opportunity of a lifetime. Attorney General Hubert H. “Skip” Humphrey, III, and his team (Tom Pursell, Doug Blanke and Luanne Nyberg, among many others) also deserve credit as the driving forces behind this case.

pages of documents that have now been released to the public,² will carry on long after the money from the settlement³ has been spent. It is the public health community's hope that the contents of these documents will become widely known. In a peer reviewed article published in the *Journal of the American Medical Association*, Dr. Channing Robertson and I reported on some of the documents that we used for the trial.⁴ The focus of the article is on documents about addiction, low tar/low nicotine cigarettes, cigarette design, and nicotine manipulation.⁵ We wrote the article because we believe it critical for the community at large to be aware of the evidence introduced in this trial and to understand the actions and behavior of the tobacco industry. The trial documents should be used to protect the public health by helping shape national policy toward the tobacco industry.

A central issue that the industry continues to deny is that they sell a drug delivery device (cigarettes) which delivers an addicting drug (nicotine).⁶ Though nicotine's addictive properties were acknowledged internally by the tobacco industry in the early 1960s, they publicly denied this.⁷ The basis for that public denial was made clear in a 1980 Tobacco Institute document from Mr. P. C. Knopick to Mr. W. Kloepfer, senior vice president for public relations:⁸ "Shook, Hardy [& Bacon, LLP, is a Kansas City, Missouri, law firm that has directed legal strategy for the industry⁹] reminds us,

2. See *State ex rel. Humphrey v. Philip Morris Inc.*, No. C1-94-8565, slip op. at 2 (Minn. Dist. Ct. July 14, 1995) (establishing a depository for "timely and efficient control and management of discovery in this action").

3. See Henry Weinstein, *Big Tobacco Settles Minnesota Lawsuit for \$6.6 Billion*, L.A. TIMES, May 9, 1998, at A1.

4. See Richard D. Hurt, M.D. & Channing R. Robertson, Ph.D., *Prying Open the Door to the Tobacco Industry's Secrets About Nicotine*, 280 JAMA 1173, 1173-1181 (1998).

5. See *id.* at 1173.

6. See generally Stanton A. Glantz et al., *Looking through a Keyhole at the Tobacco Industry: The Brown and Williamson Documents*, 274 JAMA 219 (1995) (documenting tobacco industry strategies employed to avoid products liability litigation).

7. See *id.* at 220.

8. See Trial Exhibit No. 14303, *State ex rel. Humphrey v. Philip Morris Inc.*, No. C1-94-8565 (Minn. Dist. Ct.) (memorandum from P.C. Knopick to W. Kloepfer, Tobacco Institute, dated Sept. 9, 1980) The trial exhibits cited herein are available at a website provided by Blue Cross and Blue Shield of Minnesota. See <<http://www.mnbluecross tobacco.com>>.

9. See Peter Hanauer et al., *Lawyer Control of Internal Scientific Research to Protect Against Products Liability Lawsuits: the Brown and Williamson Documents*, 274 JAMA 234 (1995) (discussing how the tobacco industry's attorneys have responded to the threat of products liability litigation arising from smoking induced diseases). See,

I'm told, that the entire matter of addiction is the most potent weapon a prosecuting attorney can have in a lung cancer/cigarette case. We can't defend smoking as 'free choice' if the person was addicted."¹⁰

Proclaiming smoking to be a matter of free choice is another of the industry's long standing public relations tactics called the "wrap yourself in the flag" ploy,¹¹ which involves promoting the "free choice" concept as being the American way and intertwining that message with freedom and other civil rights.¹² The acknowledgement of the addictive nature of nicotine was found in hundreds of documents. Sir Charles Ellis, a scientific advisor to British American Tobacco ("BAT"), in a 1962 document stated, "What we need to know above all things is what constitutes the hold of smoking, that is, to understand addiction."¹³ Others were more blunt, such as a 1978 Brown and Williamson memo: "Very few consumers are aware of the effects of nicotine, i.e., its addictive nature and that nicotine is a poison."¹⁴ Many documents spoke to the issue of the threshold dose of nicotine, such as a 1980 Lorillard document summarizing the goals of an internal task force, one of which was to, "[d]etermine the minimum level of nicotine that will allow continued smoking. We hypothesize that below some very low nicotine level, diminished physiological satisfaction cannot be compensated for by psychological satisfaction. At this point smokers will quit, or return to a higher T&N¹⁵ brands."¹⁶

Perhaps the most surprising finding in our document review

e.g., Lisa Bero et al., *Lawyer Control of the Tobacco Industry's External Research Program: the Brown and Williamson Documents*, 274 JAMA 241 (1995) (examining the tactics of the tobacco industry lawyers, who used selected research project results to influence public policy).

10. Trial Exhibit No. 14303, State *ex rel.* Humphrey v. Philip Morris Inc., No. 31-94-8565 (Minn. Dist. Ct.).

11. Victor Crawford, A Personal Revelation by a former tobacco lobbyist, Address at the American Society of Addiction Medicine's Eighth National Conference on Nicotine Dependence (Oct. 14, 1995).

12. *See id.*

13. Trial Exhibit No. 11938, State *ex rel.* Humphrey v. Philip Morris Inc., No. C1-94-8565 (Minn. Dist. Ct.) (publication entitled "The Effects of Smoking: Proposal for Further Research Contracts with Battelle," BAT, dated Feb. 13, 1962).

14. Trial Exhibit No. 13677, State *ex rel.* Humphrey v. Philip Morris Inc., No. C1-94-8565 (Minn. Dist. Ct.) (memorandum to M.J. McCue entitled "Future Consumer Reaction to Nicotine," dated Aug. 24, 1978).

15. Presumably, "T&N" denotes "tar" and "nicotine".

16. Trial Exhibit No. 10170, State *ex rel.* Humphrey v. Philip Morris Inc., No. C1-94-8565 (Minn. Dist. Ct.) (internal tobacco company memorandum dated Feb. 3, 1980).

was evidence of industry-wide efforts spanning three decades to alter the chemical form of nicotine to increase the percentage of free base nicotine delivered to smokers.¹⁷ Outside the industry little was known about this, and even in testimony before Congress, cigarette company CEOs denied that the industry manipulated nicotine,¹⁸ a position defended in testimony in the Minnesota tobacco trial by Mr. Geoffrey Bible, CEO of Philip Morris.¹⁹ Mr. Bible also expressed surprise and shame at a survey performed for Philip Morris in 1974²⁰ where children fourteen or younger were being interviewed about their smoking behavior.²¹ He expressed the same feelings²² about a 1979 Philip Morris document which said amongst other things, "Marlboro dominates in the 17 and younger category, capturing over 50 percent of this market,"²³ and a 1975 memo entitled, "The Decline in the Rate of Growth of Marlboro Red."²⁴ In this latter memo, author Myron Johnston states, "Most of these studies have been restricted to people age 18 and older, but my own data, which includes younger teenagers, shows even higher Marlboro market penetration among 15- to 17-year-olds."²⁵ Despite a trial exhibit entitled, "Young smokers—prevalence, trends, implications, and related demographic trends," which contained the statement, "This report deals with only one of these trends—teenage smoking and attitudes toward smoking together with related demographics,"²⁶ his testimony demonstrates that Mr. Bible remained somewhat defiant:

17. See Hurt & Robertson, *supra* note 4, at 1175.

18. See Jeffrey Taylor, *Tobacco Firm Releases Data About Nicotine*, WALL ST. J., Mar. 2, 1998, at A20.

19. See Transcript of Proceedings, State *ex rel.* Humphrey v. Philip Morris Inc., No. C1-94-8565, 1998 WL 89675, at *1-*34 (Minn. Dist. Ct. Mar. 3, 1998).

20. See Trial Exhibit No. 10497, State *ex rel.* Humphrey v. Philip Morris Inc., No. C1-94-8565 (Minn. Dist. Ct.) (A study by The Roper Organization, Inc. of smoking habits among young smokers dated July 1974).

21. See Transcript of Proceedings, State *ex rel.* Humphrey v. Philip Morris Inc., No. C1-94-8565, 1998 WL 89675, at *5 (Minn. Dist. Ct. Mar. 3, 1998).

22. See *id.* at *6-7.

23. See Trial Exhibit No. 11808, State *ex rel.* Humphrey v. Philip Morris Inc., No. C1-94-8565 (Minn. Dist. Ct.).

24. See Trial Exhibit No. 2557, State *ex rel.* Humphrey v. Philip Morris Inc., No. C1-94-8565 (Minn. Dist. Ct.) (memorandum discussing the decline in the Marlboro Red brand growth rate, dated May 21, 1975).

25. *Id.*

26. Trial Exhibit No. 10339, State *ex rel.* Humphrey v. Philip Morris Inc., No. C1-94-8565 (Minn. Dist. Ct.) (industry report dated Mar. 31, 1981).

Q. Do you think it is good for Philip Morris to be reporting to a number of people within the company, including people in management, about average daily consumption of teenage smokers, not even teenagers, 12 to 18?

A. No, I don't think that's appropriate, sir.

Q. You're ashamed of that, aren't you sir?

A. Well, I'm ashamed of it, but I don't know the circumstances under which this was done.²⁷

Mr. Bible apparently urged Thomas Osdene (retired Philip Morris research scientist) to tell the truth and not plead the Fifth Amendment.²⁸ "First and foremost, the company wants the truth told."²⁹ Osdene pleaded the Fifth Amendment numerous times during his deposition when confronted with internal documents.³⁰ One document was in Osdene's own handwriting and concerned a Philip Morris research laboratory in Cologne, Germany, in which he wrote, "Ship all documents to Cologne. We will monitor in person every two to three months. If *important* letters or *documents* have to be sent, please send to home. I will act on them and destroy."³¹ It would have been fascinating to have heard the truth from Osdene, but he availed himself of his constitutional right against self-incrimination. We are, however, free to draw the obvious inference.

Though most view the documents as the true legacy of the trial, the industry has tried to put a different spin on their importance. Dan Donahue, a senior vice president and deputy general counsel of the R.J. Reynolds Tobacco Company, has recently downplayed the importance of the documents.³² He remarked that the documents show only that the tobacco industry is filled with

27. Transcript of Proceedings at 6143, State *ex rel.* Humphrey v. Philip Morris Inc., No. C1-94-8565, 1998 WL 88330, at *21 (Minn. Dist. Ct. Mar. 3, 1998).

28. See U.S. CONST. amend. V. ("[N]o person shall . . . be compelled . . . to be a witness against himself.")

29. David Shaffer, *Ex-tobacco Researcher Takes Fifth During Trial*, ST. PAUL PIONEER PRESS, Feb. 14, 1998, at A1.

30. See *id.*

31. Trial Exhibit No. 2501, State *ex rel.* Humphrey v. Philip Morris Inc., No. C1-94-8565 (Minn. Dist. Ct.) (undated list detailing what was to be done with the internal tobacco documents).

32. See David Hanners, *Tobacco Suit's Legacy Yet to be Seen, Now Settlement Spent, Uses of the Once-Secret Industry Archives are Key*, ST. PAUL PIONEER PRESS, Dec. 30, 1998, at A1.

people who write a lot of memos.³³ He is quoted as saying, "The best way to deal with [the many memos] is not on a document-by-document basis, because any and every industry is going to be peopled by people who write down dumb things. We have historically taken the position of 'Don't look at what people wrote down, but look at what was done.'"³⁴

It is difficult to conceive of how such a senior official at R.J. Reynolds could so cavalierly try to dismiss the documents, especially those like the report to the board of directors of R.J. Reynolds on September 30, 1974, entitled, "1975 marketing plans presentation, Hilton Head, September 30, 1974."³⁵ In this document, one of the key opportunities to accomplish the goal of re-establishing R.J. Reynolds' market share was to "increase our young adult franchise"³⁶ The report provided: "First, let's look at the growing importance of this young adult in the cigarette market. In 1960, this young adult market, the 14-24 age group, represented 21 percent of the population."³⁷ Does Mr. Donahue expect us to believe that a presentation to his company's board of directors was written by "people who write down dumb things?"

In a 1980 R.J. Reynolds document entitled, "MDD Report on Teenage Smokers (14-17)", a future CEO, G. H. Long, wrote to the CEO at that time, E. A. Horrigan, Jr.³⁸ In this document, Mr. Long is lamenting the loss of market share for the 14- to 17-year-old smokers to Marlboro:³⁹ "Hopefully, our various planned activities that will be implemented this fall will aid in some way in reducing or correcting these trends."⁴⁰ One wonders if Horrigan and Long would agree with Mr. Donahue's assessment about the people who wrote internal memoranda. Mr. Donahue also ignores the fact that the documents released as part of the Minnesota tobacco trial spanned the industry and several decades and were often written by or presented to the highest officials in the companies. The "dumb people" defense is meaningless, particularly if one judges the in-

33. *See id.*

34. *Id.*

35. Trial Exhibit No. 12493, State *ex rel.* Humphrey v. Philip Morris Inc., No. CI-94-8565 (Minn. Dist. Ct.) (dated Sept. 30, 1974).

36. *Id.*

37. *Id.*

38. Trial Exhibit No. 13101, State *ex rel.* Humphrey v. Philip Morris Inc., No. CI-94-8565 (Minn. Dist. Ct.) (memo dated July 22, 1980).

39. *See id.*

40. *Id.*

dustry's intelligence by the success of their business.

II. THE CIGARETTE – A TWENTIETH CENTURY EPIDEMIC

Tobacco has been a part of life in the Western Hemisphere for as long as there has been recorded history.⁴¹ However, cigarettes were not popularized until the twentieth century.⁴² In the late 1800s, cigarettes were beginning to be mass-produced, but even as recently as 1905, fewer than four billion cigarettes were consumed in the United States.⁴³ Camel, the first modern cigarette (a blend of Turkish, flue-cured, and burley tobacco), was not introduced and mass-marketed by R.J. Reynolds until 1913.⁴⁴ By 1915, consumption of cigarettes had risen to more than seventeen billion cigarettes/year and to almost ninety billion/year by 1925.⁴⁵ It was not until much later that cigarette-caused diseases began to be a major health problem. The prototype of these diseases is lung cancer, which prior to 1900 was a rare disease.⁴⁶ One early specialist, A.M. Adler, wrote in 1912: "On one point, however, there is nearly complete consensus of opinion, and that is that primary malignant neoplasms of the lungs are amongst the rarest form of disease."⁴⁷

As the number of lung cancer cases began to rise in the 1930s, many theories were advanced as to causation, including influenza, syphilis, tuberculosis, inhalation of irritating gases such as war gas or exhaust fumes, or inhalation of radioactive dust.⁴⁸ Two future giants in medicine, Alton Oschsner and Michael DeBakey, were emphatic when they called attention to the cigarette as a possible etiologic factor: "It is our definite conviction that the increase in the incidence of pulmonary carcinoma is due largely to the increase in smoking, particularly cigaret (sic) smoking, which is universally associated with inhalation."⁴⁹

41. See William D. McNally, M.D., *The Tar in Cigarette Smoke and its Possible Effects*, 162 AM. J. CANCER 1502 (1932) (providing a brief history and early analysis of tobacco consumption, including cigarettes and cigars, between 1905 and 1931).

42. See *id.*

43. See *id.*

44. See *id.*

45. See *id.*

46. See generally Alton Oschsner & Michael DeBakey, *Carcinoma of the Lung*, 42 ARCHIVES OF SURGERY 209 (1941) (discussing actual and theoretical causes of lung cancer).

47. *Id.* at 209.

48. See *id.* at 214-18.

49. *Id.* at 221.

One report noted that by 1955, lung cancer had become the leading cause of cancer deaths in American men, and by 1988 surpassed breast cancer as the leading cause of cancer deaths among American women.⁵⁰ In 1994, lung cancer accounted for 91,825 deaths in American men and 57,535 cancer deaths in American women.⁵¹ Thus, together, lung cancer accounted for almost 150,000 American deaths in 1994, and for American women in particular, this number continues to rise.⁵² The report projected that, by 1998, lung cancer would account for thirty-two percent of cancer deaths in American men (compared to thirteen percent of American men dying from prostate cancer) and for twenty-five percent of cancer deaths in American women (compared to breast cancer causing sixteen percent of cancer deaths among women).⁵³ Tobacco-related diseases (heart disease, emphysema, lung cancer, etc.) account for nineteen percent of all American deaths each year, making it the leading cause of preventable death in our country.⁵⁴ Overall, over 400,000 Americans die of tobacco-caused diseases each year.⁵⁵ It has been estimated that tobacco-related illnesses cost the U.S. economy over \$130 billion each year.⁵⁶

What is not counted in any of these figures is the incalculable morbidity that accompanies tobacco-caused diseases or the suffering on the part of patients who acquire them and their families who have to see the ravages of these diseases in a loved one. Historians in the twenty-second century will look back upon this time in our history and wonder why our society allowed this to happen. They will be hard pressed to believe it was only about one thing—money.

III. THE TOBACCO INDUSTRY'S POLITICAL INFLUENCE

Given all the revelations of this industry's misdeeds brought out in the Minnesota tobacco trial, how then has the industry managed to keep the upper hand? Is it only about money and the in-

50. See Sarah H. Landis et al., *Cancer Statistics, 1998*, 48 CA. CANCER J. CLIN. 6, 8 (1998).

51. See *id.*

52. See *id.*

53. See *id.*

54. See J. Michael McGinnis & William H. Foege, *Actual Causes of Death in the United States*, 270 JAMA 2207, 2208 (1993).

55. See *id.*

56. See *Smoking Illnesses Cost U.S. \$130 Billion*, FIN. TIMES, Mar. 26, 1998, at A5.

fluence it can buy? Certainly that is part of the answer. However, it is ultimately more basic than that. The industry has developed a highly sophisticated and coordinated public relations effort which is extremely well-financed. It had its beginnings in the 1950s with the issuance of "A Frank Statement to Cigarette Smokers."⁵⁷ The influence extends to decision-makers at all levels.⁵⁸ For example, the Tobacco Institute targeted the Minnesota legislature for an intensive lobbying effort in 1985 because of the very progressive efforts in Minnesota to control smoking.⁵⁹ A Tobacco Institute e-mail stated:

Since Minnesota has seen fit to designate itself as Surgeon General Koop stated, "a model for the country" with regard to anti-smoking legislation, our only choice in this matter is a complete victory. Anything less could be used against us in other states. We will employ all means to secure that victory.⁶⁰

The lobbying influence reaches the highest levels of government as evidenced by internal Philip Morris documents relating to former Senator and former White House Chief of Staff Howard Baker and his activities as a lobbyist:

On July 3, 1989, Senator [Howard] Baker completes his one year "cooling off" period during which he could not by law lobby his former employer. Since he will now be able to play a more active role in our government affairs programs, I think it is timely to suggest ways he can most effectively complement our activities.⁶¹

57. See Trial Exhibit No. 14145, State *ex rel.* Humphrey v. Philip Morris Inc., No. C1-94-8565 (Minn. Dist. Ct.) (Tobacco Industry Research Committee advertisement addressing unfavorable medical research, dated Jan. 4, 1954); Trial Exhibit No. 14127, State *ex rel.* Humphrey v. Philip Morris Inc., No. C1-94-8565 (Minn. Dist. Ct.) (Tobacco Industry Research Committee Meeting progress report dated Jan. 18, 1954, detailing advertising activities).

58. See Trial Exhibit No. 14488, State *ex rel.* Humphrey v. Philip Morris Inc., No. C1-94-8565 (Minn. Dist. Ct.) (e-mail memorandum summarizing industry lobbying activities in Minnesota).

59. See *id.*

60. *Id.*

61. Memorandum from Jim Dyer of Philip Morris Management Corp. to David Greenberg and Kathleen "Buffy" Linehan, also of Philip Morris Management Corp. (June 29, 1989).

The document then goes on to describe Senator Baker as "a unique intelligent source", a "high level advocate", a "master strategist", and a "goodwill ambassador."⁶² "Because of his great stature both as a senator and chief of staff, Senator Baker enjoys access that few Washingtonians can ever hope to achieve."⁶³ "Senator's Baker's attachment to this company gives us an effective high level advocate of our policies."⁶⁴ In a subsequent memo dated March 8, 1990, from Jim Dyer, the director of Philip Morris's Governmental Relations Office, concerning Lewis Sullivan, the secretary of Health and Human Services, "Senator Helms further complained about Secretary Sullivan's statements, only to be assured that Sullivan did not speak for the administration formally."⁶⁵

Recent evidence of the power of the industry came to light in 1998, with a bill sponsored by Senator John McCain which would have significantly increased the price of cigarettes and put into place an effective tobacco control program.⁶⁶ This bill was defeated⁶⁷ after the industry spent millions on intense lobbying, including an extensive national television ad and media ad campaign. They killed the McCain Bill with a simple message that was repeated over and over. That message was that the McCain Bill represented increased taxes, more big government and was not about preventing kids from starting to smoke. The industry chooses its messages carefully and then puts them out in a repetitious and convincing manner to the public. Mr. David Bernick, lead lawyer for Brown & Williamson, summed it up well in his opening statement in the Minnesota tobacco trial: "Listen to our positions carefully. They were carefully crafted. They mean a specific thing."⁶⁸

IV. THE HEALTHCARE SYSTEM AND TOBACCO

What, then, is the current status of the healthcare system as it relates to tobacco, and what more could be done to enhance that

62. *Id.*

63. *Id.*

64. *Id.*

65. Memorandum from Jim Dyer to David Greenberg, Philip Morris Management Corp. (Mar. 8, 1990).

66. See Bob Hohler, *Senate Kills \$1.50 Cigarette Price Hike*, BOSTON GLOBE, May 21, 1998, at A1.

67. *See id.*

68. Transcript of Proceedings at 1116, *State ex rel. Humphrey v. Philip Morris Inc.*, No. CI-94-8565, 1998 WL 36945, at *30 (Minn. Dist. Ct. Jan. 27, 1998).

system and more closely collaborate with the legal system? The Joint Commission for Accreditation of Healthcare Organizations in the early 1990s mandated that there be smoke-free policies for hospitals.⁶⁹ That has been a slow and tedious process, but such policies have been very effective in encouraging smokers to stop smoking.⁷⁰ These policy changes actually have brought us back to the norm because hospitals did not always allow smoking. In 1952, Dr. Lennox Johnston wrote in the British journal *Lancet*, lamenting the fact that smoking was encroaching in to areas where it previously was not allowed such as the drawing room, bedroom, workroom, place of entertainment.⁷¹

In recent years, the Agency for Health Care Policy and Research has developed and disseminated a science-based set of guidelines for smoking cessation.⁷² Unfortunately, there are few intervention services that are available in medical centers throughout the country, and there is a lack of reimbursement for these intervention services. Hopefully, this will change in the future because if better reimbursement is available it is more likely that intervention services will be provided. While prevention is important and we should continue to work toward this end, intervention is a key factor to rapidly reducing the toll of tobacco-related diseases. When a smoker stops smoking, the chances of having a heart attack are reduced dramatically in the first few years, and with continued abstinence, the risk of developing cancers related to smoking are also significantly reduced. Thus, providing smoking cessation services are among the most cost-effective medical interventions available.⁷³

From a research perspective, the National Institutes of Health ("NIH") devotes a disproportionately small amount to tobacco disease research than the importance of the problem dictates.⁷⁴ For example, tobacco-related research accounts for about 1.1% of the

69. See Kenneth P. Offord et al., *Effects of the Implementation of a Smoke-Free Policy in a Medical Center*, 102 CHEST 1531 (1992).

70. See *id.*

71. See Lennox M. Johnston, *Cure of Tobacco-Smoking*, LANCET 480, 481 (1952).

72. The Smoking Cessation Clinical Practice Guideline Panel and Staff, *The Agency for Health Care Policy and Research Smoking Cessation Clinical Practice Guideline*, 275 JAMA 1270 (1996).

73. See Ivan T. Croghan et al., *Cost-effectiveness of Treating Nicotine Dependence: The Mayo Clinic Experience*, 72 MAYO CLIN. PROC. 917 (1997).

74. See John R. Hughes & Anthony Liguouri, *A Critical View of NIH Research Funding on Smoking*, TOBACCO CONTROL (forthcoming).

NIH budget,⁷⁵ but as cited earlier, smoking-related deaths account for nineteen percent of all deaths in the country.⁷⁶ The total dollars spent by NIH for tobacco-related research in 1995 was \$92 million.⁷⁷ Contrast that with AIDS. There have been approximately 400,000 Americans to die of AIDS since 1982,⁷⁸ and as noted earlier, over 400,000 Americans die each year of tobacco-related diseases.⁷⁹ Throughout the Department of Health and Human Services for 1997, there will be almost \$7 billion spent on AIDS research and treatment.⁸⁰ At NIH alone, \$1.6 billion are devoted for AIDS research in 1998 with \$153 million for AIDS vaccine research.⁸¹ Because of this kind of commitment to research and treatment, the deaths from AIDS in the U.S. peaked around 1995 and have begun to decline.⁸² That shows the potential for an effective, well-funded, research program at the national level even for a deadly and seemingly hopeless disease such as AIDS. A similar approach is needed for tobacco.

In medical education, we also have not done a very good job because there is no real focus in our medical schools for tobacco-related diseases, prevention, or intervention services. Most of the topics have to do with tobacco-related diseases, and they are scattered throughout the curricula of medical schools. Specifically, there is no requirement for intervention training. For a substance which causes so much death and disability, there is a need for more emphasis in our medical schools and postgraduate training programs.

Tobacco issues also do not do well in the medical literature. Though there have been tens of thousands of articles about tobacco-related diseases in the last fifty years, most have been written in journals of lesser stature and lower impact. *The New England Journal of Medicine* has the highest impact factor of 22.7 but publishes very few articles on tobacco, amounting to approximately five

75. *See id.*

76. *See* McGinnis & Foege, *supra* note 54, at 2208.

77. *See id.*

78. *See* NATIONAL INSTITUTES OF HEALTH, NIH FACT SHEET: HIV/AIDS VACCINE RESEARCH (May 15, 1998).

79. *See* McGinnis & Foege, *supra* note 53, at 2208.

80. *See* NATIONAL INSTITUTES OF HEALTH, NIH FACT SHEET, HIV/AIDS VACCINE RESEARCH (May 15, 1998).

81. *See id.*

82. *See* David Brown, *AIDS Death Rate in 97 Down 47%; New Drug Treatments Credited; Overall U.S. Mortality Fell 3%*, WASH. POST, Oct. 8, 1998, at A1.

articles out of 574 articles published per year.⁸³ *The Journal of the American Medical Association*, with an impact factor of 5.3, publishes thirty two articles about tobacco out of 992 articles published per year, while *Lancet*, with an impact factor of 15.2, publishes six per 853 articles per year.⁸⁴

There is also a fair amount of apathy amongst healthcare providers when it comes to this issue. When readers were asked what they wanted from a general medical journal, tobacco-related diseases and tobacco itself ranked fifty-fifth.⁸⁵ Topics such as computers, obesity, clinical practice guidelines, alternative medicine, etc., were in the top ten cited as topics of interest.⁸⁶ Tobacco rated number twenty-four amongst topics that editorial experts felt that a general medical journal should address.⁸⁷ Managed care, death and dying, genetics, and quality of care were in this group of experts' top ten.⁸⁸ Some of the apathy may be the relative pessimism that providers have about the ability of smokers to stop smoking but has also been influenced by the tobacco industry's carefully crafted public relations effort, which promotes smoking as a matter of choice, i.e. the "wrap yourself in the flag" tactic. In court and in public, the industry spokespeople say that since over 50 million Americans have stopped smoking, it is simply a matter of choice and that smokers, when they really want to stop, can do it. Those of us who treat patients know that simply is not the case for most smokers. Furthermore, most smokers begin as teenagers who may choose to smoke those first cigarettes but certainly do not choose to nor believe they will become addicted.

Finally, there is no organized or focused effort on lobbying this issue. Presently, the lobbying efforts concerning tobacco are spread across multiple organizations, and there is not one that focuses only on tobacco. Furthermore, lobbying by the healthcare industry has to do mostly with healthcare financing and/or regulations. In addition, there is not a constituent group that can bring lobbying efforts to bear such as has been done with AIDS or breast

83. See Anthony Liguori & John R. Hughes, *Where is Smoking Research Published?*, 5 TOBACCO CONTROL 37, 38 (1996).

84. See *id.*

85. See George D. Lundberg et al., *A Comparison of the Opinions of Experts and Readers as to What Topics a General Medical Journal (JAMA) Should Address*, 280 JAMA 288, 289 (1998).

86. See *id.*

87. See *id.*

88. See *id.*

cancer. It is puzzling why some organizations, specifically women's organizations, have not taken smoking forward as an issue since it is such an important health risk for women, and it is clear that the tobacco industry targets women for their products.

V. WHAT CAN WE DO BETTER?

What, then, can be done to improve the tobacco prevention and cessation efforts from the healthcare community? First, the healthcare community needs to confront head-on the tobacco industry's main message that smoking is about choice. We need to develop a consistent counter message and adopt the industry tactic of repeating that message over and over again. Clearly, cigarettes are a drug delivery device and deliver an addicting drug. It is also clear that most smokers start smoking as teenagers, a fact that the industry has known and exploited for decades. Teenagers who start smoking may have chosen to do so but they do not choose to become addicted. That happens because of nicotine, the drug.

Secondly, there is a need to intensify and focus our lobbying efforts across organizations much like the tobacco industry has done through the Tobacco Institute. The companies have all gotten together and provided resources to the Tobacco Institute which speaks with one voice, gives out clear messages, which are repeated over and over again. Perhaps the voluntary organizations such as the American Lung Association, the American Cancer Society and other healthcare organizations should learn from the industry about how to implement a unified effort. A taskforce made up of members from these two groups plus the American Medication Association, the American College of Cardiology, the American College of Physicians, etc., could be called together to work out the details. By combining forces they might be able to launch an effective lobbying effort.

Thirdly, as with AIDS research, there is a need for a permanent office at NIH to coordinate tobacco research throughout NIH.

Fourthly, Congress should increase the tobacco tax to fund more NIH research for tobacco control, treatment of tobacco-related diseases, and intervention services. A tax increase not only could be used for funding such activities, but it is well-known that increased taxes or prices of cigarettes also reduce consumption and reduce start-ups by young people. Though there is published data on this, perhaps the most telling data comes from the tobacco in-

dusty documents themselves. In a letter from Myron Johnston to Jon Zoler at Philip Morris on September 3, 1987, on the subject "Handling an excise tax increase," Johnston laments the fact that the round of price increases in 1982-83 "caused two million adults to quit smoking and prevented 600,000 teenagers from starting to smoke. . . . We don't need to have that happen again."⁸⁹ A tax increase combined with an education and research program, including mass media, grassroots and community-based efforts, has enabled California to reduce the smoking rate to about eighteen percent, second only to Utah.⁹⁰

Fifthly, we should petition editors of high-impact journals, such as *The New England Journal of Medicine*, to take a more active role in not only publishing tobacco-related articles but also encourage them to be more proactive in this very serious public health problem. We also need to develop and implement a standard curriculum for tobacco in our medical schools which would include prevention and intervention services.

Finally, it is clear that members of the healthcare community need to work more closely with the legal profession to bring about reform of the tobacco industry. Providing expert advice on addiction and the health consequences of smoking is within the realm of many health care professionals' competence. Health care professionals should be encouraged to serve as witnesses in lawsuits against the industry. An important factor that will influence the ability of attorneys to recruit expert witnesses will be the assurance that the attorneys will adequately prepare the expert for deposition and trial.

89. Trial Exhibit No. 11591, State *ex rel.* Humphrey v. Philip Morris Inc., No. C1-94-8565 (Minn. Dist. Ct.) (Myron Johnston memo to Jon Zoler, Philip Morris Inc., Sept. 3, 1987).

90. See *Taxes, Religious Beliefs Affect Smoking Rates*, ORANGE COUNTY REGISTER, Nov. 6, 1998, at A22.

