

# Tobacco: the epidemic we could all avoid

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Imagine a unique epidemic disease. It originated in the Americas and was introduced into Europe nearly 400 years ago, but remained relatively dormant until the early twentieth century. It has since emerged to become the major avoidable cause of death and disability in the UK and many other developed countries. The epidemic is unique in that it involves a non-infectious cause, a man-made vector, and leads to premature death and disability through a broad spectrum of clinical diseases including lung cancer, chronic bronchitis, emphysema, ischaemic heart disease, peripheral vascular disease, sudden infant death syndrome, childhood asthma, and many others. The cause is tobacco and the main vector the cigarette.

Smoking-related diseases currently account for more than 100 000 deaths in the UK each year.<sup>1</sup> Some of these deaths occur in utero, infancy or childhood, but the majority are in middle age or later life.<sup>2,3</sup> In most countries more men than women die from smoking-related disease<sup>4</sup> because men have tended to be the first section of the population to take up cigarette smoking in large numbers. In the peak years of male smoking in the UK, from around 1950 to about 1970, the majority of British men were estimated to be smokers<sup>5</sup>; by 1990 this proportion had fallen to about 30%<sup>6</sup> so we can perhaps now expect male mortality from smoking to begin to show a similar downward trend. Not so for women, however, who were targeted as a market by the tobacco industry well into the 1980s<sup>7</sup> and who are now the group in whom tobacco-related disease is increasing fastest in the world's more affluent countries.<sup>8</sup> If so, then in future women will replace men as the predominant users of medical services for lung cancer, chronic airflow obstruction, and other smoking-related disease,<sup>8</sup> and their children will be the ones most likely to suffer early respiratory illness, middle ear disease, impaired lung growth, or to die suddenly and unexpectedly in their sleep.<sup>9</sup> A man-made epidemic indeed.

How has this been allowed to happen? Some would argue that the epidemic developed during a period of ignorance of the adverse effects of smoking, which did not begin to become generally accepted by the public until after the Royal College of Physicians and US Surgeon General's reports in the early 1960s.<sup>10,11</sup> Whether governments or the medical profession in the UK or in other countries could have done more to protect the public from the adverse effects of smoking once highlighted in these reports is now perhaps a matter of only historical interest, but a forgiving view might consign the majority of the epidemic in developed countries to history as an unfortunate accident that could not have been predicted. A more critical appraisal might be that, at the very least, smoking-related disease occurring in those who have taken up or continued to smoke since the early 1960s, or in those exposed to environmental tobacco smoke as a consequence, represents a major failure of health planning and legislation. This is disease that could have been prevented.

The tragedy now, however, is not only the damage caused by tobacco in developed countries, but the fact that the epidemic is now spreading throughout the developing world in much the same pattern as originally occurred in the West. In these newly affected areas men have again tended to be the first group to take up smoking to a

widespread degree, but are followed a few years or decades later by women.<sup>12</sup> As a result, while the market for cigarettes is starting to shrink in the world's richest countries, it is growing much faster in the developing world. To the industry the solution to the problems of the increasing public awareness and response to the damage caused by smoking in the USA and Western Europe appears to be to learn to live with imposed or voluntary tobacco control measures, fight or settle the court cases, use advertising, sponsorship and other publicity campaigns to try to preserve the dwindling market, and quietly take the product elsewhere. According to estimates presented at the recent World Conference on Tobacco or Health in Beijing, the number of tobacco-related deaths in the world each year will increase in the next quarter century from three to ten million<sup>13</sup>; of these the vast majority will occur in the developing world and 30% in China alone. This is the real world epidemic. Some populations have yet to be exposed to – or at least take up – cigarette smoking in large numbers, but many have and more will follow. Unless radical action is taken, the epidemic in the developing world will be massive.

In the face of a problem of such scale it can be difficult to see how any individual or professional group can achieve anything more than token opposition, but there is in fact a great deal that health professionals involved in respiratory medicine could do. In developed countries where the prevalence of smoking may now be starting to decline in many sectors of society it is still essential to protect and promote that progress, and to avoid complacency. The support of medical professionals is crucial to the success of the public policy changes necessary to control smoking, including comprehensive bans on advertising and sponsorship, progressive increases in taxation on tobacco products, bans on smoking in public places, enforcement of restrictions on sales to children, and many other initiatives. The adoption of smoking cessation strategies which have been shown to be effective and for which clear practical guidelines exist<sup>14</sup> is another major opportunity for disease prevention relevant to respiratory medicine, cardiology and many other disciplines, yet in the UK at least, smoking cessation services tend to be pursued with relatively little enthusiasm in hospitals or in primary care, and nicotine replacement therapy is priced beyond the reach of many of those who most need it. The teaching of techniques to identify and support smokers who wish to give up the habit is also a highly neglected area of undergraduate and postgraduate training<sup>15</sup> which we could perhaps drive more actively. At a more general political level, however, those of us who live in countries with thriving tobacco industries also need to accept that, if we are acting to reduce the use of tobacco products in our own country on the grounds of hazard to health, we cannot in all conscience condone the export of the same product elsewhere. The cigarette manufacturing industry needs to be closed down, not redirected to the export market. The adoption of "ethical" foreign policies in relation to the export of products designed or known to cause injury and suffering, as recently embraced by the new UK government, should surely also embrace a complete ban on tobacco exports.

Tobacco control represents a major challenge for respiratory medicine which, as a specialty, has experienced epidemic increases in many diseases but none of which, in global terms, is likely to be as important as the epidemic arising from tobacco. One of the dangers of the recent legal settlements in the USA<sup>16</sup> and the welcome signs of increasing determination to enforce effective tobacco control in UK and European government policy is that many of those most experienced in dealing with the problems caused by this epidemic may start to think that the problem is over. For most of the world, it is just beginning.

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