

THE ASSOCIATION OF SMOKING AND DISEASE

I believe it will not be possible indefinitely to maintain the rather hollow "we are not doctors" stance and that, in due course, we shall have to come up in public with a more positive approach towards cigarette safety. In my view, it would be best to be in a position to say in public what was believed in private i.e. to have consistent responsible policies across the board. Because smoking has become a social problem, cigarette manufacturers must become more, rather than less, socially responsive. It is likely that in the next decade the cigarette manufacturers will become increasingly involved with those concerned with social policy in the health and medical fields.

The basic assumptions on which our policy should be built must be recognised and challenged or accepted. A preliminary list of assumptions is suggested:

- 1) The association of cigarette smoking and some diseases is factual.
- 2) Many smokers will continue to find smoking beneficial or pleasurable and will continue to smoke.
- 3) In much of the world manufacturers will be free to compete.
- 4) There will be increasing control over the conditions under which competition will be practised.
- 5) Smokers will look to both Government and manufacturers for guidance and protection.
- 6) The tobacco smoking habit is reinforced or dependent upon the psycho-pharmacological effects mainly of nicotine.
- 7) The smoking habit will continue to be of interest to the chemical industry which will aim increasingly to participate in it or replace it.
- 8) Attempts will be made to find pharmacological agents alternative to nicotine and non-tobacco materials in cigarettes will increase.

On these assumptions various policy alternatives emerge. Competition can take place within the framework of statutory requirements or league tables. It can be concerned with peripheral

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product qualities or claims or direct health claims may be made or implied. Is it still right to say that we will not make or imply health claims? In such a system of statutory control, can we completely abdicate from making judgments on our products in this context and confine ourselves to presenting choices to the consumer? In a league table position should we take advantage of a system of measurement or reporting in a way which could lead to misinforming our consumers? Should we aim to develop cigarettes which give, say, low TPM under machine smoking conditions but which will give high TPM to the average human smoker? As league tables develop to cover specific chemical compounds, should we aim at low league table positions at the expense of increases in other compounds which we judge to be harmful? Should we include man-made substitutes in cigarettes as soon as we are cleared to do so, or should we wait for official encouragement to do so or should we first satisfy ourselves, with the best advice we can get? Should we actively seek alternatives to nicotine?

There are no simple answers but my own views are as follows.

The overriding long term aim should be to provide the best service we can for our consumers. This means providing only the minimum physiologically active agent necessary and, as far as possible eliminating side effects, e.g. low nicotine, low tar. It also means that we should explore and communicate the contra-indications. Accepting that there will be no unique product design solution to our problem, we must ensure that our consumers have a choice between genuine alternatives and are sufficiently informed to exercise their choice effectively.

In my view, the establishment of league tables does not mean that the cigarette companies can contract out of responsibility for their products: the league tables should be regarded only as a partial specification. We should not allow them to lead us to abdicate from making our own judgments. "We are not doctors", in my view may, through flattery, lead to short term peace with the medical establishment but will not fool the public for long. We should aim to get the best advice we can, to work as effectively as we can within whatever political framework is established with the object of serving as well as we can those who wish to smoke. This means we should not aim to exploit a league table position unless in our judgment, on balance, the total hazard associated with the particular product lies in the area relative to other products which the consumer might reasonably expect. In practice, this is virtually the current B-A.T. position but it will become important, I think, to spell it out and for Millbank to lay down the necessary guide lines as the situation develops.

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On the other hand, I do not think we can sustain our present position with regard to health claims and still pursue a policy as outlined above. To inform the consumer, i. e. to offer him an effective choice, health implications will have to be stated by government or industry or both and within the broader areas, Companies may well have to bring home the health implications at the least for different classes of their products. I think we should plan a positive campaign to influence opinion leaders in appropriate countries where we operate in order to inform them of the health significance of the product options which could now be offered to the public. Meanwhile, we should also study how we could inform the public directly.

Further, we should develop health orientated cigarettes for one or two specific markets; this might focus attention quite effectively on any change in policy which might be necessary to sell them.

We might also increase the present very small effort aimed at finding or creating alternatives to nicotine. This might be coupled with some positive P.R. effort to rectify to some extent the current picture of nicotine as a harmful constituent of smoke.


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