

American Medical Women's Association
Position Paper on Principals of Tobacco Control & Prevention

Part I. Background

A. General Health Effects

Smoking is the leading cause of preventable death in the United States, and increasingly, around the world. More than 400,000 Americans die of smoking-attributable causes each year (1). Currently, worldwide smoking is estimated to cause 3 million deaths each year and this is expected to increase to 10 million deaths a year by around 2020. Approximately half of all long term smokers will die from smoking-related disease; one-quarter in middle age (35-69), losing 20 to 25 years of life expectancy, one-quarter in old age (70+), losing, 5-10 years of life expectancy (2).

The majority of deaths attributed to smoking occur from lung cancer, coronary heart disease, emphysema and chronic bronchitis. Other important causes of smoking-attributable death include cancer of the larynx, oral cavity, esophagus, bladder, kidney, pancreas and stomach, stroke, atherosclerotic peripheral vascular disease and aortic aneurysm (3).

Although the prevalence of smoking has declined dramatically since 1965, the decline has slowed in the last few years. In 1993, the prevalence of female smoking was 22.5 %, while male prevalence was 28.0%. Smoking was far more common among people with lower levels of education; 13.5% of those with 16 or more years of education were smokers, as opposed to 36.8% of those with 9-11 years of education (4).

The nicotine contained in tobacco products is responsible for their addictive potential. The 1988 Report of the Surgeon General concluded that, "The pharmacological and behavioral processes that determine tobacco addiction are similar to those that determine addiction to drugs such as heroin and cocaine." (5).

B. Environmental Tobacco Smoke (ETS)

The landmark report of the U.S. Environmental Protection Agency (EPA) entitled *Regulatory Health Effects of Passive Smoking: Lung Cancer and Other Disorders*, released in January 1993, designated ETS a Group A (known human) carcinogen. The report also estimated that ETS causes 3,000 deaths from lung cancer in nonsmokers each year. The report also outlined the significant health effects of ETS exposure for infants and children. This includes exacerbation of existing asthma, causing new cases of asthma and an increased risk of lower respiratory tract infections (6).

The American Heart Association has concluded ETS is a major preventable cause of cardiovascular disease and death (7). As many as 62,000 deaths from ischemic heart disease in non-smokers may be attributed to ETS exposure (8). Other research links ETS exposure with an increased risk of cancer at sites other than the lung.

Legislative and voluntary measures to reduce the public's exposure to ETS have increased dramatically in recent years; local measures are the most common, and may be the most effective. However, there is a critical need for further educational and policy measures.

C. Women and Smoking

Women who smoke experience all the negative health consequences that men who smoke do; in addition, they increase their risk of cervical cancer, premature menopause and impaired fertility (9). Each year, more than 50,000 women die from lung cancer - more than die of breast cancer. Between 1950 and 1990, lung cancer deaths among women increased by more than 500 percent (10). In 1990, 18.4% of pregnant women smoked throughout their pregnancy (11). Although many women quit smoking upon learning they are pregnant, the majority of these resume smoking within 1 year of delivering their baby.

Smoking during pregnancy is associated with reduced infant birth weight, intrauterine growth retardation, and pre-term birth. Many studies have documented an increased risk of SIDS among mothers who smoke and among mothers exposed to ETS (12,13). Women who smoke have a 25-50% higher rate of fetal and infant deaths as compared with nonsmoking mothers.¹⁴ It has been estimated that smoking is responsible for as many as 141,000 spontaneous abortions each year among women who desire to keep their pregnancies.¹⁵

D. Youth and Smoking

3,000 young people become regular smokers each and every day. The average age of smoking initiation is 14.5 years; almost all first use of tobacco occurs before high school graduation. Although the prevalence of smoking among youth declined sharply in the 1970s, the decline slowed significantly during the 1980s.

Fortunately, smoking among black youth has declined dramatically; in 1993 4.4% of black high school seniors smoked as compared with 22.9% of white high school seniors. 18.2% of female high school seniors smoked in 1993 (16,17). Tobacco use is associated with alcohol and illicit drug use. Tobacco is generally the first drug used by young people who proceed to alcohol, marijuana and harder drugs. Many adolescent smokers are addicted to cigarettes and suffer withdrawal symptoms during quit attempts.

Youth are strategically important for the tobacco industry. Currently, young people are exposed to a variety of forms of cigarette advertising and promotion, which appears to increase their risk of smoking.

E. Economic Costs of Tobacco Use

Tobacco induced disease is a serious financial burden for society. The Office of Technology Assessment estimated that, in 1990, smoking-related illnesses cost the nation \$68 billion in health care costs, lost earnings from work, and loss of future earnings from work." The U.S. Consumer Product Safety Commission estimated that in 1990, the costs of deaths, injuries and property damage from cigarette-ignited fires was approximately \$4 billion.¹⁹

F. Tobacco Use Internationally

Smoking is increasing in the developing world, in contrast to most of the developed world in which smoking rates are declining. Part of this increase is due to internal factors social, cultural and economic - such as rising income, changing social norms and an increase in women entering the labor force. However, the increased smoking prevalence may also be attributed to external pressures from Transnational Tobacco Companies (TTCs) (20). In many developing countries, a lack of systematic surveillance of smoking, prevalence, smoking

morbidity and mortality and related issues, hinders tobacco control and prevention efforts (21,22). Several policies and programs have served to promote the sale of US cigarettes abroad. Between 1985 and 1990, the United States Trade Representative conducted four investigations on restrictions on the importation of US cigarettes. Trade threats were successfully used against several nations to force them to open their markets to US cigarettes and US style advertising and promotion.²³

The impact of the entry of a TTC into a previously closed market is often very dramatic. In addition, the TTCs have clearly targeted women in the developing world. Virginia Slims, for example, was introduced into Asia at a time when less than 10 percent of females were smokers.²⁴ Since opening of the Japanese market in 1986, smoking rates among Japanese females have risen from 8.6% to 18.2%. Currently, 27% of 20-29 year old Japanese women smoke.

G. The Tobacco Industry's Role in Promoting Tobacco Use

Tobacco is a unique substance. Tobacco is the only "consumer product" which when used exactly as the manufacturer intends, is lethal. In addition, tobacco use became widespread, and the tobacco industry became entrenched economically and politically around the world, well before its dangers were appreciated. For these reasons, tobacco demands unique treatment in the public policy arena.

Part II. AMWA Agenda

A. Individual Commitment

As physicians and physicians-in-training, we recognize our responsibility to promote the health of our patients.

Therefore, AMWA members are encouraged to take appropriate action to prevent smoking by youth and encourage current smokers (adult and youth) to-quit. To the extent feasible, AMWA members are encouraged to participate in community based tobacco control and prevention activities. AMWA members are also encouraged to join and support other organizations engaged in tobacco control and prevention.

B. Cessation

AMWA supports continued research and refinement of effective smoking cessation techniques, especially research into those most suitable for women and girls. In addition, AMWA supports third party coverage of smoking cessation and related services, including prescription of nicotine replacement therapy. AMWA members are encouraged to become knowledgeable in effective smoking cessation techniques.

C. Progressive Tobacco Control and Prevention Policy

AMWA supports a broad range of progressive tobacco control and prevention policies. These include, but are not limited to:

The provision of comprehensive school-based health education, including effective tobacco prevention curriculum;

A universal ban on tobacco product advertising, promotion and sponsorship;

Increasing the excise tax on all tobacco products. The tax should be increased to at least the average levied by other developed countries, and it should be indexed to inflation;

Comprehensive tobacco control programs, to include paid media campaigns, tobacco policy research, health education, community-based projects and other activities, at the state and/or federal level. These may be funded through increased tobacco excise taxes or other means; Protection of non-smokers, especially children, from ETS, through legislation and policy measures which eliminate smoking in indoor and appropriate outdoor environments (including workplaces and public places);

Enactment and enforcement of stringent measures to protect youth from purchasing tobacco products, whether through vending machines, over-the-counter sales or sampling;

Increased government oversight of tobacco company activities. Specifically, we urge the Justice Department and the Federal Trade Commission to vigorously regulate the practices of the tobacco companies, as is appropriate to their respective mandates. Furthermore, we urge the Food and Drug Administration to exert authority over tobacco products;

Support for measures which limit the exportation of American tobacco and tobacco products to overseas markets;

Financial support for developing countries to monitor and control the epidemic of tobacco use many are now experiencing;

Support for programs to assist tobacco farmers and those engaged in the manufacturing of tobacco products to make the transition to growing non-lethal crops or to other occupations;

Urge elected officials to refuse to accept campaign funds from tobacco companies, their subsidiaries and related sources;

Oppose the pre-emption of state and/or local authority to limit the sale of tobacco to minors, promote clean indoor air, regulate advertising, promotion and sponsorship, and to take other steps to control and prevent tobacco use.

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