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If preventable, why not...?

Blocking an EC directive on tobacco advertising is sentencing some UK citizens to premature death

Next month London Transport will prohibit smoking on its buses, mirroring similar action by British Rail on commuter trains in and out of London. Welcome though these initiatives are, they will make a tiny impact on one of the major health problems of our time. The New Zealand health minister has recently commented that "effective action against the lifestyle killers can in the end only come from governments." Yet on tobacco policy successive British governments have a dreadful record of delay and prevarication. Although two of our citizens, Austin Bradford Hill and Richard Doll, pioneered the study of the links between smoking and serious disease, Britain has consistently been among the last countries to adopt effective antismoking policies. Not only have they not followed much of the Western world in implementing active policies against smoking; they have also blocked key directives in the European Community.

Worldwide at least 19 countries now have a total ban on advertising tobacco. Twelve of these are in Europe, and legislation pending in France will bring it into line with the rest in 1993. The French bill proposes a ban on all direct and indirect advertising and sponsorship, a ban on smoking in public, stronger health warnings on cigarette packets, and swingeing rises in the cost of tobacco. Earlier this year the New Zealand government adopted one of the strictest set of laws anywhere, banning any advertising and ensuring that its citizens had a right to smoke free air.

Community policies

The policies currently being developed in the European Community on smoking are largely linked to harmonising legislation by the start of the single market in 1992. So far the commission has proposed several directives, with varying success. The United Kingdom has gone along with three sensible directives—on standardised health warnings, maximum tar levels of cigarettes, and closing the loophole on television advertising—while choosing a softer option on a fourth: to rely not on legislation but on "implementation by other means" to ban smoking in public. It has also opposed a directive on harmonising taxes, which would force Britain to lower the excise duties on tobacco (hence lowering prices). As Nigel Lawson, a previous Chancellor of the Exchequer, pointed out, maintaining high tobacco taxes will actually benefit health. It is perhaps all the more surprising therefore that Britain should be so obdurately opposed to a further directive—drastic restrictions on tobacco advertising. This opposition raises yet again the question whether the government understands the inordinate burden on this country of premature mortality and preventable disease related to tobacco smoking.

Directive on promotion

The directive on promotion would "severely restrict" tobacco advertising, both in the press and on hoardings and elsewhere: it would allow portrayal only of the packet and the product without any creative treatment. At a meeting in Brussels in early December, however, both the United Kingdom and Germany again opposed this draft, preparing to rely on their "voluntary agreements." Yet the government's own Health Education Authority opposes such agreements; and there is abundant evidence of their inadequacy. In particular they are bypassed by sports sponsorship—so that, paradoxically, the non-commercial BBC television service now plays a leading part in promoting cigarettes to children. During the 1989 Spanish Grand Prix, for example, logos and other devices provided the equivalent of 80 half minute advertisements.

Many experts would argue rather that the directive is too feeble: what is needed is a total ban on advertising. Currently four community members explicitly support a ban and another seven have indicated their support. Persuasive support for a total ban comes from the New Zealand Toxic Substances Board. Studying the link between smoking and advertising in 33 countries, it found that annual average consumption fell by 1·6% a year in countries with a total ban compared with 0·4% in countries with limited advertising.

Anyone who questions the need for further action should look again at the enormity of the medical problem. Worldwide the annual death toll is now 2·5 million, with 390 000 deaths in the United States and 110 000 in the United Kingdom. These are mostly premature deaths—men and women dying 20-30 years before the end of their natural lifespan. In the United Kingdom about 100 000 of today's 500 000 children aged 11-15 will eventually be killed by their addiction. And recent research has raised new issues—the suggestion, for instance,

that 17% of lung cancers among non-smokers are attributable to high levels of exposure to cigarette smoking during childhood and adolescence.

Given all this, not surprisingly the most recent British plea for action has come from a group of doctors. In early December the British Thoracic Society called for a united coalition of doctors to pressurise the government into introducing a model tobacco act. The new organisation would unite all those currently working on smoking and health, while the key features of the act would mirror some of the European Community directives, and also include regular tax rises, more education for the public, and more resources for smoking cessation. And the special needs of the Third World should not be forgotten, for without expert help from the West these countries are powerless to counter the epidemic that will ensue from the migration of tobacco companies there.

Such political moves are welcome, but they need reinforcing by an approach directed at individuals and in particular in health workers and politicians. The time has surely come when all those working in the NHS—and certainly all health ministers and officials—who continue to smoke should ask themselves whether they are morally justified in presenting such a dissonant message to the public. A similar personal approach should be made to members of the new cabinet, where at least two members, Mr John Major and Sir George Young, are on record as sympathising with antismoking groups.

It should also not be forgotten that, despite its brave directives, the European Community spends nearly £800m a year on tobacco subsidies, £150m of these borne by the United Kingdom. The health service needs more money and needs to make the best of its facilities. Where better to start than by following the example of other countries in tackling a largely reversible epidemic of wasteful, economically damaging disease.

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Cancer services

Patients with cancer need compassionate care from the start of their illness

The last weeks of the life of most patients with cancer are less harrowing now than they were 20-30 years ago; the philosophy of the hospice movement has permeated widely throughout the NHS, influencing doctors, nurses, and other health workers. But although physical symptoms may be at their worst in the terminal stages of cancer, much of the mental distress peaks early on—as soon as the diagnosis is suspected and long before treatment is even discussed. The general practitioner's first hints as he refers the patient to hospital, the hospital doctor's evasive insistence that he can't say what's wrong until the tests are completed, the family's uncertainty about whether or not to acknowledge the fears at the back of everyone's mind: all these conspire to make the patient feel isolated, abandoned, and often frankly terrified. At this stage, too, patients may begin to ask philosophical questions such as "Why me?" or "What did I do to deserve this?" and to re-examine, perhaps for the first time for many years, their beliefs about religion and life after death.

Lack of advice and support

Studies of patients with cancer and of their relatives after the patient's death continue to bear witness to the lack of advice and support when the disease is first recognised. These issues were discussed recently at an informal workshop of doctors, health workers, and patients. The meeting was given accounts of some pioneering cancer support services within the NHS that are financed in part by voluntary funding and was told of plans for fund raising for further examples.

What does a cancer support service provide? Firstly, and most importantly, it creates a working atmosphere in which patients and their families can feel confident that when they ask questions and express their fears and doubts they will not be fobbed off: time will be found and someone will answer the questions or find the answers if they don't know them.

A typical service will be a building or some rooms on the site of a hospital that will provide day care facilities for patients. In addition to conventional physical therapies it will also have arrangements for emotional support and counselling by a combination of volunteers and health professionals. It will have a telephone information services for patients and their relatives backed up by written materials and videos. Several of the pioneer services have also offered patients a range of alternative and complementary therapies, ranging from nutritional advice to pain relief by acupuncture and therapeutic massage. Clearly there is a demand from patients for this sort of provision—and hard line sceptics who condemn all such therapies as unproved should note, firstly, that some clinical trials have shown (for example) that acupuncture is an effective antiemetic and that a wide range of complementary treatments are available to patients attending the cancer rehabilitation unit at the Royal Marsden Hospital. Times have changed, and medical attitudes need to change with them.

We live, indeed, in an era of consumer rights, and the basic care that all patients with cancer may reasonably expect is now becoming agreed. Technical competence in diagnosis and management is necessary but not itself enough. Clinicians should now recognise that the moment a patient is suspected of having cancer emotional support needs to be provided. Clinicians who do not feel competent to give that support (or haven't the time or the inclination) should recognise that they have an obligation to delegate the task to some other health professional who has been suitably trained and who sees the task as a priority. If there is a cancer support services on site the patient may be referred there.

Role of cancer adviser

Wherever the information and emotional support are provided, they should be given to the patient and his or her "significant other"—spouse, relative, companion, or whatever. In particular, information and discussion of treatment options should take place simultaneously with the patient and the "other"—for the practical reason that they are both told the same and to avoid any suspicion that facts are being withheld from the patient.

What does a cancer adviser or counsellor do apart from