

Blame, shame and lung cancer

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Patients with lung cancer are blamed for causing their illness to a much greater extent than are patients with other smoking related diseases. This blame is unjustified, has real impacts on vulnerable individuals and needs to be systematically eliminated.

Lung cancer is the most common fatal malignancy, and there is an undeniable link to tobacco smoking in most cases. Although smoking is a contributing factor in a number of illnesses, patients with lung cancer are blamed for causing their illness far more frequently than are patients with other smoking-related diseases. This blame is laid by both healthcare providers and the wider community.

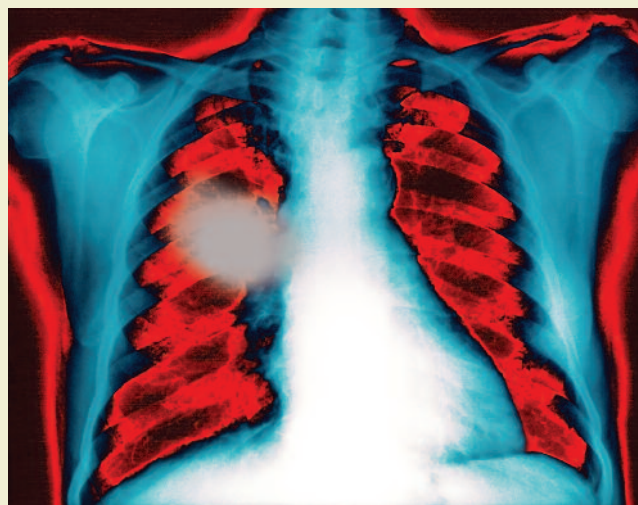
Lung cancer and smoking

The ascent of lung cancer to obtaining the dubious honour of being the number one fatal malignancy in Australia is a recent one. One hundred years ago lung cancer was rare, so much so that some people challenged its existence. It is beyond question that the incidence of lung cancer is a result of changed patterns of tobacco use. Almost all lung cancer is caused by active smoking, with a few cases from passive smoking and industrial exposures, particularly to asbestos.¹ Current smokers who develop lung cancer would not have had the disease had they not smoked, and those people with lung cancer who stopped smoking before their cancer was diagnosed would have had the cancer delayed or prevented had they quit earlier.²

Lung cancer and blame

Commonly, lung cancer patients are blamed for causing their condition. Two large surveys of a stratified random sample of Australian adults found that over 90% of respondents believed that people with lung cancer were responsible for their condition, and only 57% were sympathetic towards lung cancer patients.^{3,4} This is not out of personal ignorance of the problem. About 70% of those surveyed knew a person with lung cancer and, on average, the respondents knew more than two people with the disease. Twenty per cent of people surveyed believed that lung cancer patients should pay all of their healthcare costs, and 75% suggested they pay at least half.

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With blame goes shame. I recall vividly from my time as a young doctor, the effect of telling a smoker with advanced primary adenocarcinoma of the lung that his tumour was not of the sort caused by smoking. This was incorrect. (Although adenocarcinoma is the most common cancer in nonsmokers, most adenocarcinomas are smoking-related.) Notwithstanding that a different aetiology would not alter the outcome at all, the relief on the part of the patient and his wife was palpable.

Lung cancer in the media

Media health stories are now commonplace but few public figures talk openly about smoking-related disease and lung cancer in particular. Shortly after he had lung cancer surgery, Mr John Fahey, at the time a Federal Government Cabinet Minister, was described in a Sydney newspaper as being unprepared to blame cigarettes despite smoking for 35 years. He said: 'No lung surgeon will tell you it is caused by tobacco.'⁵ Had he asked me, I would have confidently told him that smoking was the cause.

That Mr Fahey would say this to the media speaks deeply of our society. His situation was more complex than most because he was a member of a political party that has accepted funding from the tobacco industry,⁶ and while he was the NSW State Premier, he had some influence on public policy that could have reduced smoking-related disease. That he is involved with advocacy for improved cancer care is laudable. What he now believes about smoking and causation is a private issue but he has been fortunate, to some degree, to have had time to work through the issue. The majority of lung cancer patients present with advanced disease. They must face the emotions and fears associated with a certain death at an uncertain time and with an unpredictable complex of symptoms and discomforts along the way. Negative societal attitudes directed at these patients are peculiar and add a cruel burden.

Shifting the blame

If smokers are not to blame then what or who is responsible?

The first factor was the switch (after World War I) from smoking tobacco in pipes to smoking cigarettes, particularly American cigarettes because with these the smoke has to be inhaled deeply to deliver nicotine. This was pivotal – deeper inhalation exposes the lungs to a greater carcinogen burden.

Not only did the prevalence of cigarette smoking increase markedly but people commenced smoking at younger ages. Critically, the modern cigarette has been engineered precisely so that the initial smoking experience is less unpleasant, maximising the likelihood that a young person will smoke for the short period required to establish nicotine addiction.⁷ Nicotine delivery from the cigarette is also controlled. In parallel, promotion and marketing, overt and subtle, of the product have been researched and hugely resourced. Smoking was thus normalised within our society.

Current lung cancer patients are collateral damage from social change and some of the great corporate successes of the last century.

Why is the smoker not to blame?

A chief argument against total personal responsibility is the age at which people start smoking. Although the public relations arms of tobacco companies may talk of smoking as an adult choice, the reality is different.

Almost all adult smokers start smoking during early teenage years.⁸ Moreover, features of addiction are common in teenage smokers.⁹ Adolescents become addicted to smoking at an age where society has determined that they are not mature enough to drink alcohol, drive or vote. To suppose that they can make adult choices in assuming the long term health risks is absurd.

People currently being diagnosed with lung cancer were young at a time when smoking was the ‘norm’, at least among young men.¹⁰ If these people were growing up now, their chance of being a smoker would be much lower.

Another important reason that complete responsibility cannot be conferred to the smoker is the development of physical addiction. Most adult smokers have tried to quit; only a few are successful at their first attempt.

Why is the blame laid?

Why cannot blame and shame associated with lung cancer be eliminated easily? Firstly, the almost complete association with smoking means that there can be no diffusion across multiple causal factors outside the victim’s control. Secondly, the majority of our society is made up of never smokers or past smokers without lung cancer. This majority has a clear view of the health risks of smoking, and judges its own practice (that is, not smoking) as meritorious while judging the behaviour of smokers as

the reverse. Thirdly, among the general public, sex, computer games, mobile phone use and excessive eating have all been described as addictive. Loose use of terminology dilutes the impact of the critical reason – addiction – why smokers cannot claim total responsibility for their predicament.

Does all this matter?

Beyond the personal issues of further burdening a terminally ill patient, blaming patients with lung cancer does matter if the atmosphere of blame adversely affects public policy.

There is a prevalent attitude that lung cancer is effectively addressed by antismoking campaigns. While an admirable mode of prevention, this in no way addresses treating or curing the disease, in the same way that advocating safe sex alone would be ineffective in addressing the needs of those with HIV infection.

In comparison with breast cancer, lung cancer is a poor relation when it comes to public and private medical research efforts. Three times as many people die in Australia from lung cancer as from breast cancer.¹¹ We have a National Breast Cancer Centre (NBCC) and a host of institutes and research groups. NBCC activity was expanded in 2001 to include ovarian cancer – but note, three times as many women die from lung cancer as from ovarian cancer.¹² That there is no national lung cancer centre or institute reflects that the lung cancer lobby is absent, inarticulate, ineffective or a combination of these.

What is the solution?

The strategies applied elsewhere are likely to be ineffective. There will almost certainly never be a lung cancer cohort such as there is with HIV infection to advocate eloquently for altered community attitudes and public resource allocation. At Action on Smoking and Health (ASH), we are asked occasionally by the media for contacts with a young attractive woman who has lung cancer. Media stories of that ilk might play a positive role in raising awareness and funding but would be a dishonest representation of lung cancer – albeit little more than a 33-year-old is typical of women with breast cancer. (In NSW, 1% of lung cancer and 2% of breast cancer cases are diagnosed before age 35.)¹² A well known celebrity with lung cancer who was prepared to be an advocate and fortunate to live long enough to do so would be a perverse blessing but history suggests that this combination is unlikely.

The solution cannot rest with odious comparisons with other diseases to which blame could be but is not attached. Patients with HIV infection are rightly treated whether their infection is acquired by blood transfusion or anonymous, unsafe sex. Women with cervical cancer are not shunned if they did not participate in screening. The solution begins when patients, such as mine, are honestly told that their cancer is caused by smoking but that this will not influence their care in any way. A consistent

public message must be spread so that what is achieved at a 'micro' level can be reflected on a 'macro' level where public policy and resource allocation are determined.

A change in the broader community approach to smoking as a health issue would put the problem of blame in a context within which it could be addressed. Smokers must be recognised as victims rather than criminals. Well-funded smoking prevention and cessation activities and support services should be based on the facts that children not adults take up smoking and that smoking is maintained in spite of quit attempts rather than in their absence.

Politicians have a special responsibility. Both the Liberal

A public health perspective

Matthew Peters is surely correct in his advocacy of equal, compassionate care of patients irrespective of the cause of their illness. Indeed it is of concern that some patients suffering from tobacco-associated lung cancer are blamed for their problems when they are most vulnerable. It can be argued, however, that shame is a legitimate public health tool, particularly when addressing so serious a problem as lung cancer.

Australian society has been a world leader in the war against tobacco use, and it is difficult to think of additional measures that might further decrease the prevalence of cigarette smoking here. We could make tobacco an illegal product or tax tobacco beyond the capacity of smokers to pay – but these would lead inevitably to a black market with all its associated evils. Therefore, we are left largely with social ostracism of both smokers and, equally importantly, those in the tobacco industry in our efforts to reduce further tobacco use.

It will take time, probably decades, for social ostracism to be sufficiently effective for tobacco smoking to become a historical oddity. However, there are signs that shame is beginning to have an effect. To avoid the shame of potentially harming a child's health, adults are starting to avoid smoking in the presence of children. Similarly, it is becoming socially unacceptable to smoke in enclosed places; shame and guilt can often be seen on the faces of smokers who are standing on the pavements outside office buildings. Tossing of cigarette butts is seen as shameful in that it damages the environment; hopefully this too will provide another scenario where tobacco smoking is unacceptable.

In this evolving social climate against smokers, it is inevitable they will be blamed sometimes for their misfortunes. It is a sad price smokers must pay if we are to overcome this lethal public health problem.

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Party and the Australian Labor Party have accepted donations from tobacco interests. There should be questions in relation to the movement of politicians or their staff from positions of public service to tobacco companies. Only the most naïve would suppose this to be on the basis of ability alone and not continuing connections to the corridors of power. The public is right to be concerned about the effects of these factors on decision making in relation to smoking-related disease.

Conclusion

There are strong elements of blame and shame associated with lung cancer. Moreover, there is a sound basis to argue that this adversely influences public policy and resource allocation. It is time for the priority allocated to lung cancer to be one that befits its status as the leading cancer killer in our country – all other considerations being dismissed.

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