A guide to deciphering the internal codes used by the tobacco industry

Many tobacco control researchers and advocates are now aware of the value of the internal tobacco industry documents made public as a result of the state attorney generals’ Master Settlement Agreement. A growing body of document based research provides dramatic insight into industry initiatives and strategies. These published studies also provide countless examples of the secret language commonly used by the tobacco industry internally. As observed in Philip Morris’ Dictionary of tobacco terminology; “Every specialized field has its own language.” The language of the internal documents is frequently comprised of project names, acronyms, abbreviations, numerical identifiers, and other coded terms, presented without any clear indication of their definitions or meanings. These coded terms can make the task of document research very daunting: like trying to learn a foreign language without an instructor or reference dictionary.

Familiarity with the codes used internally by manufacturers is critical to successfully conducting document research and interpreting internal industry activities. Although individual efforts have described the codes relevant to particular topics of research, no single research group has sought to identify the full extent and types of code languages used by the industry or the patterns governing internal codes. Many tobacco companies do maintain internal lists of terms. For example, over a dozen Philip Morris documents are devoted solely to providing their personnel with guides to the company’s extensive acronyms, abbreviations, codes, and terminology. Ultimately, however, the majority of terms and project names are not covered in internal lists, and understanding the meaning of internal codes necessitates both careful research as well as recognition of the common patterns and conventions employed throughout this terminology.

A critical role for tobacco control researchers is to develop and share information that can facilitate and expedite future research. A recent monograph, A guide to deciphering the internal codes used by the tobacco industry, available on the Harvard School of Public Health website (http://www.hsph.harvard.edu/php/ptrtcphome.html), identifies and describes a number of industry code lists and highlights different types of industry codes, both formal and informal, ranging from acronyms to “catchy” names, from numerical coding and letter patterning to signs of the zodiac and the names of world rivers. This monograph is part of a larger research project funded through a grant from the National Cancer Institute to list and define codes and project names used internally by the industry in areas related to product research, including product development, testing, and design. The ongoing list is housed online at http://www.tobaccocontrol.org/profiles/. We encourage other document researchers to expand this list by posting codes and definitions that they have encountered. The public health community has benefited in extraordinary ways through the availability of the documents to all; now we need to work together to identify and expose the secrets hidden within these documents.

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REFERENCE


Table 1 Perceptions of truth telling by tobacco companies in 2004

<table>
<thead>
<tr>
<th>Total (n = 2997)</th>
<th>Smokers* (n = 638)</th>
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</tr>
</thead>
<tbody>
<tr>
<td>Never tell the truth</td>
<td>26.7</td>
<td>32.0</td>
<td>28.7</td>
</tr>
<tr>
<td>Mostly do not tell the truth</td>
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</tr>
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<td>15.5</td>
<td>21.5</td>
<td>10.7</td>
</tr>
<tr>
<td>Always tell the truth</td>
<td>0.8</td>
<td>1.8</td>
<td>0.4</td>
</tr>
<tr>
<td>Don’t know/can’t say/refused</td>
<td>4.6</td>
<td>5.5</td>
<td>3.6</td>
</tr>
</tbody>
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Data weighted by age and sex according to Australian Bureau of Statistics population Census data for 2001.

*Smokers include those who smoke daily, weekly or less than weekly.
†Former smokers include those who had smoked at least 100 cigarettes or an equivalent amount of tobacco in their lifetime.

promotional brochure as sponsoring the Red Nose Day Foundation (supporting research on sudden infant death syndrome). During this period of “corporate re-imaging”, the tobacco industry also appeared prominently in the Australian news media. The Rolah McCabe trial in 2002 generated a great deal of press coverage and debate about the liability of the tobacco industry for smoking related illnesses and about their conduct in light of the Victorian Supreme Court finding that British American Tobacco had subverted the discovery process by deliberately destroying thousands of documents. To gain insight into how adults in the Australian state of Victoria perceive the tobacco industry, data from representative population surveys were analysed. Telephone interviews with Victorian adults were conducted during November and December 2002 (n = 1995), 2003 (n = 3001), and 2004 (n = 2997). Participants were asked: “In relation to issues about smoking, do you think tobacco companies—always tell the truth; mostly do not tell the truth, or never tell the truth?” Table 1 shows that, in 2004, less than 1% of Victorian adults reported they thought that tobacco companies always tell the truth. The majority of adults (79%) believed that tobacco companies mostly did not or never tell the truth. This level of distrust is comparable to South Australian adults’ perceptions in 1998, when 80% of respondents and 74% of smokers thought tobacco companies mostly did not or never told the truth. Although distrust was high in 2002, findings indicate that the Australian public is becoming increasingly wary of the tobacco industry and remain unmoved by industry attempts to paint themselves as model corporate citizens.

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doi: 10.1136/tc.2005.014423

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The percentage of adults who think tobacco companies mostly do not or never tell the truth has increased in a linear fashion from 2002 (75%) to 2003 (77%) to 2004 (79%) (p < 0.001). This level of distrust is comparable to South Australian adults’ perceptions in 1998, when 80% of respondents and 74% of smokers thought tobacco companies mostly did not or never told the truth. Although distrust was high in 2002, findings indicate that the Australian public is becoming increasingly wary of the tobacco industry and remain unmoved by industry attempts to paint themselves as model corporate citizens.

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*Smokers include those who smoke daily, weekly or less than weekly.
†Former smokers include those who had smoked at least 100 cigarettes or an equivalent amount of tobacco in their lifetime.
In Australia, the Tobacco Advertising Bill 2005, which was enacted, will assist in controlling the promotion of tobacco products at events. Specifically, the proposed Tobacco Products Control Bill 2005 will ban the mobile selling of tobacco products (currently not considered to be promotion, and permitted as “selling”). It also contains provisions to prohibit the sale or supply of tobacco products via temporary premises at events that are expected to attract significant numbers of people aged under 18 years. This proposed new legislation will further restrict the marketing opportunities of tobacco companies.

I reply to the main point raised. Studies of environmental tobacco smoke (ETS) exposure and lung cancer commonly identify a group of self reported non-smokers among female subjects, an apparent relationship of ETS exposure and lung cancer commonly indicates smoking (or perhaps 106, if one also includes those women who claimed to smoke but had a CCR < 100 ng/ml).

The misclassification rate calculation is clearly based on CCR > 100 ng/ml validly indicating smoking. Yano states that I am “confused with the calculation formula” and that my “definition of misclassification was obtained by dividing those with > 100 ng/mg CCR (n = 28) by self reported non-smokers (n = 318)”.

It appears that Yano himself is confused. I had previously made it clear that the denominator should not be 318, but 98, the number of women with a CCR value indicative of smoking (or perhaps 106, if one also includes those women who claimed to smoke but had a CCR < 100 ng/ml).

The observed lack of correlation in the Japanese spousal study between CCR in non-smokers (with CCR < 100 ng/ml) and other indices of ETS exposure suggests that inaccuracy in CCR measurement at low levels may be important. However, such inaccuracy may not be relevant to the misclassification rate calculation, which merely attempts to use CCR to distinguish smokers from non-smokers. Over half the self reported non-smokers with values over 100 ng/mg actually had values of 1000 ng/mg, and it would be very surprising indeed if errors in CCR measurement were so huge that these women were really non-smokers.

Though I would be happy to see results of further studies using up to date, state of the art chemical methods to detect nicotine metabolites in self reported non-smokers, the conclusion I reached in 1995 that misclassification rates are much higher in Japanese than in
Western populations seems to be correct. I note that the existence of high misclassification rates in Asian women has in fact been independently confirmed.\(^1\)

Yano states\(^1\) that he used his data without his consent. As far as I am aware, the data never belonged to Yano. The study had been funded by the industry which had carried out the cotinine analyses (blind of self reported smoking status). I had originally proposed that the study be done, following conduct of a similar study in England, which the industry supported at my request, the results of which I reported.\(^1\) The original intention had been for Yano to be a major author, but problems arose because his interpretation of the findings differed materially from mine, due to his misunderstanding of the complexities of misclassification. Discussions took place between Yano and Proctor, who played an important role in the planning and organisation of the study on behalf of the tobacco companies who funded it; I was told that these discussions led to Yano deciding not to become a co-author, and to his misunderstanding that the work would be published by others.

I had assumed that Proctor would keep Yano informed about the status of the publication and was surprised Yano did not find out about the paper, published in 1995, until some seven or eight years later. Clearly, one of us should have kept him informed, and for this I apologise. In his original article,\(^1\) Yano states that “at no stage in my interactions with Proctor was Lee’s name or role ever mentioned”. This is surprising inasmuch as the study proposal stated that I would assist in reviewing the study design and in interpreting the data. Was Yano really unaware of the previous literature on misclassification of smoking, in which I figured prominently (see Lee)\(^1\) when conducting a study, a major aim of which concerned the determination of misclassification rates? Chapman\(^1\) considers that “it is hard to imagine a more flagrant example of attempted ghost authorship”. It is difficult to see why Chapman sees the publication as ghost authorship at all, when I proposed the study, helped in its conduct, and was published in it. The study was a joint enterprise, as I saw it, and it is perfectly normal for some of the scientists involved in a study to write a draft for others to agree to. It would clearly have been better had a version of the paper been published by both, with Yano on the author list, been published. However, Yano’s failure to understand the mathematics of misclassification made this impossible. There was no agreement I am aware of that Yano had sole rights to authorship. Had I not published the paper\(^1\) it seems that the findings would have never appeared in the public domain at all. Did Yano also have sole rights to suppress the findings?\(^1\)

At the end of the day it is interesting that, though the evidence of high misclassification rates in Japanese women has been independently confirmed,\(^1\) the relevance of this to the ETS/lung cancer relationship has been ignored in recent major reviews of ETS and lung cancer (for example, Hackshaw et al.,\(^1\) International Agency for Research on Cancer\(^1\)). I have demonstrated the major biasing effect of this finding in detail elsewhere.\(^1\)

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doi: 10.1136/tobaccocontrol.2005.014373

Competing interests: Peter Lee is a long term consultant to the tobacco industry.

REFERENCES


Should a paper with erroneous interpretations based on invalid measurements be published?

In response to Mr Lee’s comment\(^1\) which follows previous responses\(^1\) and my paper,\(^1\) I offer further comments that I believe to resolve an apparent misunderstanding of the validity and reliability of cotinine/creatinine ratio (CCR) measurement and his mishandling of the formula of misclassification. I also express concerns about the level of scientific integrity in his reporting\(^1\) of the Japanese spousal study, including his authorship.

As I demonstrated,\(^1\) all indices of nicotine exposure (ambient room, personal sampler monitors, and urine cotinine) were well correlated but poorly correlated with CCR, raising doubts about the validity of the CCR measurement. Yet Lee maintains that CCR measurement in this study was the gold standard for distinguishing true smokers from falsely reporting smokers.

There are several possibilities about why the CCR measurement may have been invalid and unreliable in this study. In 1991 when I sent the urine samples to the RJ Reynolds laboratory (where the measurement was performed), I was informed that the urine sent with the sample had sublimated before it reached the laboratory. This suggests that the sample was not maintained at low temperature before analysis. Cotinine measurement is temperature sensitive and measurement after the sample is exposed to high temperature can make the measurement inaccurate.\(^1\)

As I calculated,\(^1\) the misclassification and subject effects is dependent on the prevalence of smoking. With only a slight (3%) inaccuracy in CCR measurement, low agreement correct CCR measurement, and 3% of true smokers are classified as non-smokers by erroneously high CCR and 3% of true non-smokers are classified as smokers by erroneously high CCR (for the sake of simplification, I assume no false reports by the subjects). We get the results shown in table 1.

As can be seen, Lee’s formula for misclassification and subjects with high CCR and low CCR and self reported smokers with low CCR.

Lee insists that reverse misclassification is relatively unimportant in his “abundant” mathematical publications. However, I note that this seems to have real lack of statistical power, using 28/106 as the misclassification rate of self reported smokers in his original study,\(^1\) having quietly switched to 28/98 for this rate after I pointed out his confusion. Despite his claim that reverse misclassification is implausible, it was observed as a fact.\(^1\)

Lee states that as far as he is aware “the data never belonged to Yano”. He should be aware that I developed the questionnaire, my results were independently confirmed,\(^1\) and I supervised the survey at the study area (Shizuoka), erroneously referred to in Lee’s paper as “Shizoka”.\(^1\) I planned and ordered the data input, performed the data analysis, and made the discussion on the experience of possible sample damage (from dry ice sublimation) the commercial

**BOOK REVIEW**

The millennium development goals and tobacco control: an opportunity for global partnership

Written by Katherine M Esson, Stephen R Leeder. Published by World Health Organization, 2005. ISBN 92-4-159287-7

MDGs and tobacco: a glimmer of hope—but only if matched by dollars

Many agencies and governments have great expectations for the poverty reduction targets of the millennium development goals (MDGs). These were adopted at the Millennium Summit of the United Nations in New York in September 2000 with the aim to “ensure that globalization becomes a positive force for all the world’s people”. The eight goals of the MDGs are specifically targeting issues regarded as critical to progress in reducing poverty including eradicating poverty, achieving universal education, promoting gender equality, reducing child mortality, improving maternal health, combating HIV/AIDS, malaria and other diseases, and ensuring environmental sustainability. As conceived, the MDGs had a strong focus on poverty reduction, but the aim to improve health outcomes for marginalised millions was virtually silent on tobacco control.

The recent publication of The millennium development goals and tobacco control: an opportunity for global partnership is a welcome contribution to fill many of the initial gaps in the MDG goals impacted by global tobacco use. Since 2000, the World Health Organization and other UN agencies have done considerable work on the adverse role that tobacco use has not only on health but also on communities, economies, and the environment. Esson and Leeder give a very brief introduction to the impact of tobacco on health and then seek to establish the link between tobacco and poverty in each of the eight MDGs. The book summarises one of the economic arguments that often rates highly with governments: “Tobacco has a negative impact on the balance of payments of many countries. Two-thirds of 161 countries, where data are available, are net importers of tobacco, losing more hard currency in cigarette imports than they gain in exporting tobacco.”

After giving an overview of the relationship between tobacco use and the MDGs the book divides issues into six sections: the WHO Commission on Macroeconomics and Health (CMH) and the WHO Framework Convention on Tobacco Control; up to date information on consumption in developing countries. Two sections cover the links between tobacco and poverty at the national and individual levels covering the first seven of the MDGs. A section addresses the need for global partnerships in development and resourceing, particularly in funding mechanisms, for achieving the MDGs, and another summarises ways in which the current goals can be enhanced by a focus on strengthened tobacco control related to the particular goals or targets.

**Developing countries**

The book points out that focusing on tobacco use in developing countries has often seemed a distraction. The data from developing countries is often poor, agencies often see water and sanitation as more critical than tobacco, the economic and health costs are seen as an issue in high income countries rather than those with limited health and economic impact data, and the developing countries often see the negative effects of reduced production of tobacco as an economic benefit.

The authors, Katherine Esson and Stephen Leeder, have brought together a compendium of useful research and information in a way that can have greater impact with policymakers and governments. This includes a review of the trends in global numbers of smokers, the transition of health impacts from tobacco to developing countries, and the role of trade liberalisation. The book fills a major gap in MDGs and can assist tobacco control advocates and policymakers to ensure inclusion of tobacco control goals in country policy and strategy reviews. The issues must be placed on the agenda of planning agencies, decision makers, and politicians.

A summary of the key issues from this report was usefully included in the August 2005 publication by WHO of Health and the millennium development goal. In July 2004 the United Nations Economic and Social Council (ECOSOC) passed a resolution indicating how pivotal this issue is by stating, “…tobacco control has to be recognised as a key component of efforts to reduce poverty, improve development and progress towards the Millennium Development Goals (MDG). Tobacco control needs to be included in the programmes of countries on achieving the MDGs. Tobacco control also needs to be a key component of development assistance programmes in general.” Without this inclusion, it’s unlikely that the majority of developing countries will achieve their desired MDGs.

H Stanton
Secretariat of the Pacific Community, Noumea, New Caledonia
harleys@spc.int

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4. Yano E. Japanese spousal smoking study revisited: how a tobacco industry funded paper

**Table 1** Hypothetical populations with 3% inaccurate CCR measurement

<table>
<thead>
<tr>
<th>CCR (ng/mg)</th>
<th>Smoker</th>
<th>Non-smoker</th>
<th>Total</th>
<th>Lee’s misclassification formula</th>
</tr>
</thead>
<tbody>
<tr>
<td>A: if 10% smoke</td>
<td></td>
<td></td>
<td></td>
<td>CCR, cotinine/creatinine</td>
</tr>
<tr>
<td>High (&lt;100)</td>
<td>97</td>
<td>27</td>
<td>124</td>
<td></td>
</tr>
<tr>
<td>Low (&lt;100)</td>
<td>3</td>
<td>873</td>
<td>876</td>
<td>27/124 = 0.21 (21%)</td>
</tr>
<tr>
<td>Total</td>
<td>100</td>
<td>900</td>
<td>1000</td>
<td></td>
</tr>
<tr>
<td>B: if 30% smoke</td>
<td>291</td>
<td>21</td>
<td>312</td>
<td></td>
</tr>
<tr>
<td>Low (&lt;100)</td>
<td>9</td>
<td>679</td>
<td>886</td>
<td>21/121 = 0.06 (6%)</td>
</tr>
<tr>
<td>Total</td>
<td>300</td>
<td>700</td>
<td>1000</td>
<td></td>
</tr>
</tbody>
</table>

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