



In the Public Health Perspective, There Is Not a Rational Approach of E-Cigarette Use

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To the Editor:

I have read the editorial by Hopkinson on e-cigarette use that was published recently in the *Journal* (1). In the content, “a rational approach” has been moved to the agenda (1). There is not a rational approach on e-cigarette use. At this point, I would like to draw the readers’ attention to a couple of issues. First, e-cigarettes are accepted as “new-generation” tobacco products (2), and as with all the others, they should be prevented 100% like the other traditional tobacco products. The World Health Organization (WHO) strongly recommends tobacco control facilities (3). Unfortunately, the tobacco industry is misusing the terminology of “harm reduction,” which was first defined in the content of the Framework Convention on Tobacco Control (4) of WHO many years ago.

From a public health perspective, I would like to emphasize two important issues. The first one is the Precautionary Principle in public health. This principle is one of the fundamental principles of public health, and it is basically used when science needs more data on a threat. We should not harm when there is not sufficient evidence to avoid the risks (5). It was in the 1950s when Sir Richard Doll and A. Bradford Hill discovered evidence of a link between cigarette smoking and lung cancer (6), and, fortunately, they changed the route to tobacco control. Many others followed and supported tobacco control. Very similar to those days, threats are also growing today, to which science should immediately respond. Unfortunately, as a commercial determinant of health, the tobacco industry produces new-generation tobacco products, including e-cigarettes, products that are heated but not burned, and so forth, which can easily deceive consumers, especially those of younger generations. As scientific evidence grows on e-cigarette use, the Precautionary Principle should be accepted as a public health guide to be followed to protect the health of the community from one of the most prevalent and risky substances, in all forms. The second issue that I would like to draw the readers’ attention to is the ethical responsibility of science and its scientists. From an ethical perspective, health risk comparisons should be made between smokers and nonsmokers rather than comparing the smokers’ levels of vulnerability and harm. It is not acceptable to say to someone, “You’ll not suffer from Disease A, but you may have Disease B.” So, e-cigarette risks, with their many known and scientifically proven hazards (2), should not be compared with the risks of other tobacco products. One, and the only logical, comparison of the e-cigarette users’ data should be conducted with the nonsmokers’ data.

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I know that science is growing every day, which is very promising. I would strongly suggest that distinguished scientists remember the tactics of the tobacco industry every time with their broader public health perspective in science. I would also expect their strong reactions against the tobacco industry to help achieve a “tobacco-free world,” which is on the agenda. ■

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Reply to Pacheco Gallego and Farber, to Young et al., and to Aslan

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From the Author:

In addressing the American Thoracic Society Tobacco Advisory Group’s concerns about the U.K. government’s proposed “Swap to Stop” scheme (1), my intention was both to outline the rationale behind this approach intended to support some of the 6.4 million adult smokers in the United Kingdom to reduce their risk of premature death and disability (1) and to place it in context as one among a raft of

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policy proposals. These include raising the age of sale and a polluter-pays levy that caps tobacco industry profits on U.K. sales (2).

An additional objective was to suggest a framework of common knowledge and objectives, set out in Figure 1 (1), that could help to guide more thoughtful discussion and indeed disagreement in this area, as well as promoting solidarity with tobacco control efforts in different local contexts (3).

Some of the responses nicely illustrate the need for this. These include objections to arguments that are not made in the text (nicotine is obviously addictive if vaped; only an idiot or a scoundrel would argue otherwise), points that are not relevant to the topic (which is the impact on smokers of continued smoking vs. support to switch to vaping as one element in tobacco control policy), and rhetorical inventions used to set up a position to argue against. For example, it is a struggle to see how any reasonable reader could get from what is actually written in the editorial—"it is entirely appropriate to be concerned about the impact of youth vaping," "will cause long-term health harms which need to be understood and mitigated," and "use should be for a short a time as possible"—to the accusation of making "the erroneous assumption that there are no concerning effects."

It is worth addressing some specific concerns raised. No serious commentator describes e-cigarettes as safe. Consequences of long-term use, and of use at an early age when the lungs are particularly vulnerable, are precisely why the steps I outlined need to be taken to discourage youth vaping, a consequence of the aggressive and pervasive marketing of cheap, appealing products to children, and the failures of governments and others around both regulation and enforcement to prevent this. At the same time, the problem with simply invoking the precautionary principle in relation to adult smokers is that we know that two out of three people who continue to smoke will die from a smoking-related disease (4). We need to act based on current knowledge of relative risks and exposures, in advance of long-term epidemiological studies.

The comparison of e-cigarettes with filters and "low-tar" cigarettes may be superficially appealing, but the obvious difference is that neither of these interventions actually lower exposure to the harmful contents of tobacco smoke. In contrast, both biomarkers of exposure to harmful materials and biomarkers of health harms across a range of organs support a substantial reduction in risk for vaping compared with smoking, particularly around carcinogenesis. Of note, rather than a "critique with minimal evidence," the most recent iteration reviewing current knowledge in this area now runs to 1,468 pages (5).

Finally, I am well aware that there is a manufacturer of generic varenicline, but, as stated, it is not currently available to prescribe in the United Kingdom. On a positive note, cytisine, a stop-smoking medication with a similar effect has just (January 2024) been approved there.

In conclusion, to quote U.K. Chief Medical Adviser Professor Sir Chris Whitty, "the key points about vaping (e-cigarettes) can be easily summarised. If you smoke, vaping is much safer; if you don't smoke, don't vape; marketing vapes to children is utterly unacceptable" (6). ■

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A World Health Organization–Derived Framework for E-Cigarette Policy

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To the Editor:

After recent publications in this journal regarding the use of e-cigarettes (1, 2), I would like to draw attention to the recent World Health Organization (WHO) call to action on e-cigarettes that was published on December 14th, 2023 (3, 4). Among other recommendations, it encourages a ban on e-cigarette flavors, including menthol and synthetic menthol analogues, as well as strong restrictions on marketing, promotion, and regulation. The WHO also recommends that such regulations, as well as increasing tax, should aim to reduce appeal and harm. Also, existing smokers should be directed toward proven cessation and approved treatments. It is important to note that they outline that any country that wants to adopt e-cigarettes as cessation products should "carefully weigh national circumstances and the risk of uptake, and exhaust other proven cessation strategies." They also make it clear that these cessation aids should be regulated as medicinal products, raising the regulatory bar significantly.

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