Do respiratory physicians not care about people who smoke?

Authors: Caitlin Notley, Simon Barry and Steve Parrott

Nicotine containing vapes (e-cigarettes) are an effective tool to support people who smoke to quit tobacco. Despite this clinicians are wary of promoting vaping to their patients due to concerns that there may not be ‘enough’ evidence and about youth uptake of vaping. In this opinion article we discuss clinicians’ views of vaping and consider the implications that harm misperceptions may have for public health.

KEYWORDS: vaping, e-cigarette, smoking cessation, harm reduction

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At a recent debate in Swansea, delegates at the Asthma UK Centre for Applied Research did not vote in support of the motion that ‘Vaping is a healthier alternative to smoking and should be promoted as a useful public health strategy’. The majority vote appeared to suggest that concern for adults who smoke was outweighed by the unknown risks of vaping and the increase in the rates of young people trying vaping. Between 8 May and 17 May, 2023, we undertook a rapid survey of respiratory consultants and specialist registrars across Wales to explore whether the debate outcome was either a reflection of the particular audience or a clinical view shared more widely. Responses were received from 38 consultants (63% of all respiratory consultants in Wales) and 11 specialist registrars (31% of the total). Of all respondents, 27 (55%) indicated that they would not promote vaping as a smoking cessation tool to patients. Of these, most (25, 80%) indicated that they were concerned about the spread of vaping to young people. Only 49% supported the current Royal College of Physicians (RCP) position on vaping.

Tobacco smoking is incredibly harmful to health. We have known for the first time clear evidence of the link between smoking and early mortality. There is no other legally available product for human consumption that is so uniquely deadly. Vapes (or e-cigarettes) are the most popular consumer choice for smoking cessation support, and they are effective. The latest Cochrane living systematic review demonstrated that quit rates with nicotine-containing e-cigarettes were ∼50% higher than with nicotine replacement therapy. A nicotine-containing e-cigarette delivers nicotine fast, mimicking the nicotine absorption that people get from tobacco smoking. Therefore, e-cigarettes are a satisfying and pleasurable substitute for smoking, and allow users to switch away from harmful combustible tobacco without experiencing nicotine withdrawal. Vaping can also meet social and identity-related needs that are important to exsmokers. Vapes are seen as an attractive and pleasurable alternative to smoking, which also happen to be far less harmful to health.

Through evidence reviews, the Office for Health Improvement and Disparities has consistently concluded that ‘vaping is significantly less harmful than tobacco smoking’. Toxicological studies have demonstrated substantially reduced levels of measured carcinogens and toxicsants for people who switch exclusively to vaping and quit tobacco smoking. Evidence also shows that e-cigarettes offer a cost-effective intervention as an aid to stopping smoking. The Trial of Electronic Cigarettes (TEC) study in England involved three stop-smoking service sites using an e-cigarette starter kit. The incremental cost-effectiveness ratio was £1,100 per quality-adjusted life year (QALY) gained 12 months after the quit date and £65 per QALY over a patient’s lifetime. These results are below the accepted cost-effectiveness threshold of £20,000–£30,000 used by the National Institute for Health and Care Excellence (NICE). Moreover, declining smoking rates are likely to be partly the result of the success of vaping as an alternative to smoking. In Wales, smoking rates are now 13%, with 76% of smokers using vapes to help them quit and only 4% accessing the Public Health Wales Help Me Quit service.

The counter-argument of concern about youth uptake of vaping, which is in fact a different debate, is highly emotive. There is a balance to be struck. We wholeheartedly agree with the view of Sir Chris Whitty, the UK chief medical officer, that marketing must not promote vapes to children, and regulations should be tightened to prevent this. However, there is a need to be realistic. Teenagers will experiment with many things that are not good for their health; risk taking and experimentation are part of the process of...
becoming an adult. In 1982, 19% of 11–15-year olds were current smokers, whereas, by 2021, this figure had reduced to 3%.1 The Action on Smoking and Health (ASH) youth survey, in May 2023, reported an increase in youth experimentation with vaping from 7.7% in 2022 to 11.6% of 11–17-year olds, particularly in trying disposable vapes, but no concurrent increase in tobacco-smoking behaviour.1 It might be optimal that no young person uses inhaled nicotine of any kind, but is it not preferable that they are using a vape, with a relatively low risk profile, rather than tobacco, which will kill half of them? We need to carefully regulate and restrict marketing and packaging to avoid the appeal of vapes to young people, but going further (banning flavours or limiting sale as consumer items) would be policies that could have catastrophic effects for public health by reducing the appeal of and access to vapes for adults who so desperately need an alternative to help them quit smoking.

Many of the other counter-arguments are, quite frankly, nonsense. ‘Vaping is addicting a whole new generation of young people to nicotine’. There is no evidence that vaping leads to smoking. It is far more likely that there is a ‘common liability’ to try a range of substances in adolescence.14 If it is only vaping, then why do we care about nicotine use, in itself a relatively low harm substance? Is it that, morally, we do not like the idea of dependence or is it that we struggle with harm perceptions that distort clinical reasoning? Assessment of relative risk, or relative harm, is complex. People struggle to comprehend a distant possible risk to health from vaping, even if likely very low, compared with the very high risk of tobacco smoking. This counter-intuitive position could lead people to continue to smoke tobacco, knowingly harmful, rather than switch to something that is likely far less harmful, but ‘unknown’. However, qualified clinicians should be able to think through logically, assess the available scientific evidence and give clear advice about stopping smoking by vaping to prevent the very real risk to health that continued smoking poses to patients. We must also be clear that the harm from tobacco does not come from the nicotine. Despite this, large proportions of UK smokers and ex-smokers overestimate the relative harmfulness of e-cigarettes compared with smoking, and much of this misperception might result from views on nicotine that translate to reticence to switch to less harmful nicotine-containing products.15

Despite 15 years of population experience with no substantial evidence of harm, does concern about youth vaping, together within harm misperceptions, really stand scrutiny compared with the risks of smoking? We are concerned that emotive reactions might impact clinical decision making: do physicians hold back from congratulating their patients who have quit smoking by vaping, through a misplaced belief that ‘we don’t have enough evidence’?

To promote good health, reduce harm and prevent early death, we should support vaping as a means of smoking cessation for adults as an urgent public health priority. In our concern for children, let us not forget the health of adults. ■

References

Address for correspondence: Caitlin Notley, professor of addiction sciences, Faculty of Medicine and Health Sciences, Norwich Medical School, University of East Anglia, Norwich, NR4 7TJ UK.
Email: c.notley@uea.ac.uk
Twitter: @AddictionUEA

Caitlin Notley, Simon Barry, and Steve Parrott
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