

SPECIAL COMMUNICATION

First, tell the truth: a dialogue on human rights, deception, and the use of smokeless tobacco as a substitute for cigarettes

L T Kozlowski

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The use of smokeless tobacco as a substitute for cigarettes raises many scientific and ethical issues, as the fictitious discussion below reveals

Cast: Dr Acton—a physician and member of a leading smoking policy committee; Dr Wright—a scientist with interest in human rights ethics (both characters are fictitious and do not represent any individuals, living or dead).

Setting: Private room at a conference. These two colleagues have been allies for many years. Today they have been arguing in public. The argument starts up again.

Dr A: You don't know what you're doing. You need to stop.

Dr W: *You're* too secure in your opinions of what should and shouldn't be done.

Dr A: You don't understand how your position can be used against us.

Dr W: Science without scientific integrity is propaganda—public relations. You're so caught up in trying to be a "policy" hero that you forget your scientific roots. We must never censor or manipulate results. In your policy world, scientists are dishonest when they don't conform to the prevailing policy.

Dr A: Science is not our only context. Far from it . . . Don't imagine that any part of the tobacco industry is committed to public science or fair play with us or their victims. The tobacco industry as a whole are paid killers. They know there is no such thing as a safe tobacco product that will sell well. Their secret documents—the ones we have seen—show an industry that is no friend of the public health.

Dr W: I'll say openly to anyone—you, the press, a consumer, a legislative committee—that (a) smokeless tobacco products in the US and Sweden are safer than cigarettes to individual users and (b) smokeless could be used to substitute for cigarettes in smokers who won't otherwise quit.

Dr A: I will say openly that the Surgeon General has determined that "smokeless tobacco is not a safe alternative to cigarettes". That's our message. No tobacco products are safe. Smokeless tobacco is not a safe product, and the companies have not generally done all they might do to reduce toxins.

Dr W: A big Volvo sedan is not a "safe alternative" to a small sports car, but it is "safer". A product can be both safer and not safe. Smokeless does not cause lung cancer or other lung disease

(emphysema). Smokeless is certainly at least 60% less deadly than cigarettes and could be 90–99% less deadly than cigarettes.

Dr A: Smokeless causes deadly oral cancer. I have seen a young man's whole jaw lost to cancer. His complete lower face a shrivelled monstrosity. You don't forget that. You don't recommend a product that can do that.

Dr W: Which "product" are you talking about—cigarettes or smokeless? User for user, cigarettes cause even more, deadly oral disease than does smokeless. Public policy should care more for the deaths of the many than for the tragic images of the few.

Dr A: Smokeless is not a safe product! It is addictive! Their intent is not harm reduction. They build smokeless products so that users can progress to stronger and stronger hits of nicotine. As a physician, *my* professional ethics say "do no harm". DO NO HARM! As a physician, I could never recommend that someone expose themselves to carcinogens.

Dr W: "Do no harm" is a public relations slogan, not an ethical principle. As a physician, you prescribe drugs that kill with their side effects—liver toxicity, GI bleeding.

Dr A: Anti-tobacco lawyers would be lining up to sue us, if we made health claims for any dangerous tobacco products. I could get sued! You won't catch me advocating the use of a dangerous product.

Dr W: Advocating a dangerous product? My statement about smokeless being safer than cigarettes is *not* "advocating" smokeless for harm reduction. You could have many reasons to be against substituting smokeless for cigarettes—but one reason should *not* be because the product doesn't reduce risk to individual users.

Dr A: You come off sounding like you're in bed with the industry. These peddlers of addiction and death love your human rights rhetoric. It's damn naive to wave the banner of personal autonomy, cry out for human rights to honest information and for human rights to "informed consent". We are on a battlefield with a vile, unscrupulous enemy. Your ethical rhetoric is unethical and will kill people.

Dr W: Who *likes* or *dislikes* an idea has nothing to do with its truth value. If smokeless is safer than cigarettes (and it is), our policy should consider that, rather than deny it.

Dr A: If I accept that smokeless *may* be less dangerous to *individuals*, then you should also accept that smokeless can be more dangerous to *society as a whole*. If more people start using a less dangerous product, this product can be worse for

Correspondence to:
Lynn T Kozlowski, PhD,
Department of
Biobehavioral Health, Penn
State, 315 East Health and
Human Development,
University Park, PA 16802,
USA; ltk1@psu.edu

public health . . . We can restrict human rights (quarantine an individual), to protect the public health.

Dr W: But just how big are these risks? . . . the “risk/use equilibrium” shows that once risk is reduced greatly, it is far-fetched to suppose that the numbers of users can ever increase so much that there will be net public health loss. Your knee-jerk concern that there *might* be greater overall harm is a primitive and partial kind of policy assessment. Effect-size does matter! Another reason to be honest about estimating levels of risk. To defeat individual rights, there must be *clear and convincing danger* to society. A far-fetched, implausible risk is not “clear and convincing evidence”.

Dr A: You talk about “informed consent” and “right to information”. But what about the young. Children become nicotine addicted before the age of consent. Children need our special protection—surely “paternalism” is not a bad word when protecting children. Smokeless is a gateway drug. Smokeless is a known gateway to cigarettes. If we don’t say smokeless is just as dangerous as cigarettes, we are not doing all that we can to stop kids from using smokeless.

Dr W: Lying about levels of risk to scare kids in health communication is still lying, no matter how worthy your intent. The federal rules against deception in research should also apply to public health messages.

Dr A: You can be such a goody-goody. Federal rules against deception? What are you on about? Do you expect that health educators or physicians—when they tell a caring lie—should go to the Institutional Review Board to get permission?

Dr W: Even a “caring lie” robs individuals of autonomy, steals from them the opportunity to choose. The US government says that deception in research is not allowed unless four conditions can be met. First, the deception should not add risk.

Dr A: Add risk? How does trying to scare kids away from smokeless *add* to anyone’s risk?

Dr W: Some kids are into high risk activities. For these kids, your lie *removes* a reason to not become a smoker! You don’t know if the lie “does no harm”.

Dr A: I believe that if we don’t tell kids that smokeless is just as dangerous as cigarettes, they will take up smokeless and the gateway effect will move them on to cigarettes. Imagine the righteous complaints from parents if the public health movement doesn’t do all it can to protect our children.

Dr W: The scientific evidence for a true causal gateway effect is slight. About 3 in 4 of those who use smokeless cannot be “gateway users”, in that they either never go beyond smokeless to cigarettes or they started using cigarettes *before* they started using smokeless.

Dr A: How can you propose we practise science outside of the formal sanctions of science based governmental regulation? Our drug regulatory systems have helped create modern pharmaceutical products that must have years of testing—at the manufacturer’s expense—before they can be sold. And they are subject to post-marketing surveillance and strict controls.

Dr W: A scientist should not first look at what answers the regulatory authorities *prefer* to see, before making judgments.

Dr A: Approved, tested, and pure medicinal nicotine products *might* be used for cigarette harm reduction. But we need strong governmental drug regulation to protect the public of all ages, before advocating use of smokeless.

Dr W: Yes, we do need strong regulations to see smokeless products—with required minimum toxicity—marketed in ways that might best benefit the public health.

Dr A: It is not “free choice” or “informed consent” or “personal autonomy” when nicotine addicts are duped by slick ads, product placements, sponsorships, and promotional tricks. These smokeless ads won’t care if you quit smoking. They will promote the use of smokeless when it is inconvenient to smoke. They will target children, not just the 50 year old smoker.

Dr W: You don’t have to lie about the basic facts, to be against unethical marketing practices! Being deceptive and evasive about the facts is a twisted way for scientists to try to deal with unethical marketing. Marketing practices need to be controlled.

Dr A: Can you show me one scrap of *scientific* evidence that smokeless tobacco products can even substitute effectively for cigarettes? I can think of only one limited study—and that was industry funded.

Dr W: I don’t expect that you would support NIH funding for such a project . . . Do you really believe that studies are needed to show that traditional smokeless tobacco products *can* substitute for cigarettes? Smokeless users say so. The phenomenon of nicotine addiction says so. There are many “cases”—workplaces—where smokeless has been used when cigarettes cannot be. If cigarettes can substitute for smokeless in your gateway model, why not vice versa?

Dr A: You call for human rights. I call for scientific evidence. We need effective, science based, governmental drug regulation or I am not going to say one positive word about any tobacco products. We don’t even know if consumers will really use these products as we would intend.

Dr W: You are so sanctimonious about governmental regulation . . . when cigarettes—by far the deadliest tobacco product—are free from proper governmental regulation.

Dr A: I believe governmental regulation is required.

Dr W: I do too, . . . but I see no connection between this belief and the reluctance to be honest about what is known. Your insistence on governmental regulation may represent a utopian solution—it may never happen—not effective regulation!

Dr A: If we permit smokeless to be promoted as a substitute for cigarettes, some smokers will use it to keep on smoking and avoid quitting—they will use smokeless to cope with smoking restrictions at work.

Dr W: Even we public-health-loving advocates should have limits on how much we control others! If an adult smoker chooses to use smokeless, or for that matter, medicinal nicotine, as a bridging product, to cope with restrictions, that is their business—their decision. You want to ban Viagra too, if you learned it contributed to philandering and marriage break-up?

Dr A: “Choice” is not a word to be used for addicts. You are sabotaging the policies that most of your closest colleagues have been working toward. You can carefully speak a scientific truth and the companies will grab a fragment of what you say and squeeze it to their advantage. Be careful where your “scientific assessments” and your “scientific integrity” take you, because you can be sure that it will be at most one small step forward, and, more likely, several big steps back.

Dr W: I hope these principles will have small, constructive effects on the dialogue. That we will move closer to true science based policy and that human rights will be respected.

Imagine a smoking patient with a long standing relationship with a physician. They have tried everything—even tried medicinal nicotine as a substitute. This adult patient has a right to know that a switch to smokeless tobacco might help him stop smoking completely and could reduce disease risks substantially. I think the ethical physician should be able to discuss smokeless as an option. And I don’t think he should fear that the army of anti-tobacco litigators will swoop down on him—because to inform that smokeless is much less deadly than smoking is honest, health relevant information.

Dr A: You don’t get it. You are sabotaging the policies that most of your closest colleagues support.

Dr W: How about instead of “First, do no harm” you try, “First, tell the truth”. Just who do *you* think *you* are, to be deciding so much for so many? Who do you think you are?

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For a performance of this dialogue, visit the Tobacco Control website—
www.tobaccocontrol.com

"We really need something for people to die of"

2.7. This last point, a brutally realistic one, implies that, with a general lengthening of the expectation of life we really need something for people to die of. In substitution for the effects of war, poverty and starvation, cancer, as the disease of the rich, developed countries, may have some predestined part to play. The argument is obviously not one that the tobacco industry could use publicly. But its weight, as a psychological factor in perpetuating people's taste for smoking as an enjoyable if risky habit, should not be under-estimated.

"Cancer is an essential ingredient of life"

2.8. There is, furthermore, a certain fatalism about the general public - an acceptance of the presence of adverse factors in life - which is not shared by the medical profession or by scientists whose task it is to find ways of overcoming or countering such factors. The disillusion now being felt, for example in the United States, about the small return achieved by vast expenditure on cancer research, reflects a sense of the inescapable nature of the disease. For smokers or potential smokers, this 'inevitability' runs against the spirit of caution urged by health educators. In this particularly highly-charged area of discussion, both professionals and laymen tend to regard cancer as wholly inimical, a threat which may develop suddenly or slowly, but which is always alien to the body. In reality, of course, though in its controlled and positive aspects, cancer is an essential ingredient of life without which the cells of the human body would be unable to renew themselves.

Proposal prepared for the UK's Tobacco Advisory Council by UK firm Campbell Johnson Ltd in 1978. The whole document can be found at: www.pmdocs.com/getallimg.asp?if=avpidx8DOCID=2501160781/0803.