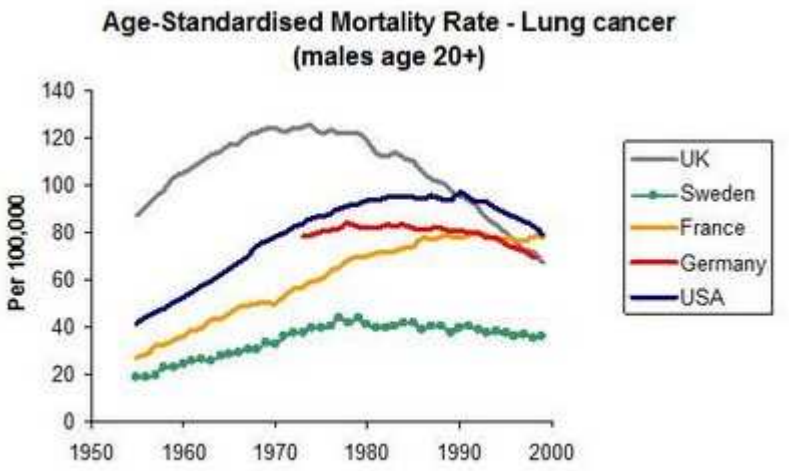
Saturday, September 01, 2007

Saying stupid things with fake sophistication



If you want to say something absolutely jaw-dropping in its idiocy, then you need to cloak it in lots of fake sophistication. And this is what ASH Scotland has done with its new position paper on smokeless tobacco.

No less than 266 references are used to support the truly stupid idea that smokeless tobacco, which can substitute for cigarettes and is far less hazardous, should be banned. Smokeless tobacco is far less dangerous because there is no, er, smoke to draw into the lungs. The red hot particles, volatile gases and thousands or organic products of combustion ingested deep into the body do the harm.

If you put that idea to any normal person they look at you as if you've lost your mind. Only in the insular world of 'tobacco control' do these ideas survive for longer than it takes to express them. In fact, there is a wealth of evidence that it is, as you would expect, a truly stupid thing to do - not least because the place where it is most widely used (Sweden - see chart) has much lower rates of smoking related deaths....

The chart shows male lung cancer mortality rates in some major countries [Source: IARC / WHO Cancer Mortality Database CANCER*Mondial*]. One country stands out: Sweden. And Sweden also has lower rates of oral cancer and other smoking-related diseases. The difference between Sweden and the others is that a high proportion of its tobacco use in Sweden is in smokeless form [view]. One of Europe's especially ludicrous policies is to ban most forms of 'oral tobacco' [Directive 2001/37/EC Art 8], though not in Sweden.

So the main ASH Scotland policy idea is that other countries should be *prevented by law* from reaching a position where more of the tobacco use is through far less harmful forms of tobacco consumption and that addicted individuals should be *prevented by law* from having access to lower risk products. What next? A ban on anti-lock brakes? Cycle helmets? Ropes while rock climbing? Any risk reduction measures at all while engaging in inherently risky behaviour? There's the warped logic of the overweening health planner behind all this... if you make a risky activity much safer, then people might not stop doing it altogether.

Confused about burden of proof
Apart from the unsettling coerciveness of such positions, there are simplistic errors in the

analysis - concerned with the handling of scientific uncertainty when making policy. Science can (and should) reserve judgement indefinitely or use 'beyond reasonable doubt' tests of evidence. But policy making requires decisions whatever the available evidence - and a decision includes "maintaining the status quo". This requires the policy-maker not to demand perfect knowledge but a 'balance of probabilities' assessment of available evidence. Throughout the document, the authors draw conclusions of the form: "*there is not enough evidence [for doing something sensible]*" and so decide to stick with doing something stupid, as if there is conclusive evidence to support the stupid ban. Which there isn't and they don't pretend there is, or even seem to recognise that there ought to be. All they've done is set a high or impossible evidential hurdle for the thing they don't like and not applied any evidential challenge whatsoever to maintaining the ban, which they do like. But what if the ban, by denying people less hazardous alternatives, is actually killing more people? It's at least plausible. And given the position in Sweden, where it isn't banned and many fewer people die, you might think that was a good starting point and expect some evidence to show that bans aren't just making everything worse. For me, the burden of proof is on those supporting the utterly insane idea of banning much less hazardous substitutes for very deadly products. Look through the ASH Scotland paper and you'll find no evidence to support a ban or give any confidence that it isn't doing more harm than good.

Confused about individual rights

But I think the thing I find most troubling about this sort of posturing is what it means at an individual level. In effect, these remote health planners are saying to a person who smokes cigarettes that they should not have access to a much less risky alternative. Where did the acquire the authority and the bare-faced arrogance to do that? How did they become so sure of themselves that they feel qualified to restrict the harm reduction options available to someone struggling with addiction? So on those estates in Glasgow, where smoking prevalence can be as high as 70%, ASH Scotland says 'no' to lower risk alternatives. You must quit. And if you don't quit - well, you might as well die.

Wrong questions

ASH Scotland solemnly poses questions like should smokeless tobacco be given a "legal designation as a harm reduction product in the UK? Eh? There's no such thing. It's a tobacco product - just much less dangerous than the norm. Or they state a preference for use of NRT for harm reduction or stopping smoking - but what if others find smokeless tobacco more effective or don't want or wont use a medicalised approach? What is the case for reducing the available options for quitting or reducing smoking? They prefer other interventions such as smoke-free places legislation and bans on advertising. All good ideas, but they don't explain explain why these are mutually exclusive with policies that reduce the harmfulness of the tobacco that is sold or why removing smoke would have a beneficial supportive 'denormalising' effect. Or why there wouldn't be additional benefits from reducing passive smoking exposure, role modelling and fire risk.

With top epidemiologists predicting 1 billion premature deaths from tobacco in the 21st Century, one might think that all options would be in play- especially as the smokeless products have done so much to keep the carnage down in the one place where they are widely used.

So for the next edition of this position statement:

1. please provide evidence that the ban you favour maintaining isn't doing more harm than good at population level by denying smokers access to much less hazardous products and opportunities to manage nicotine addiction, in the way it appears to work in Sweden. We know that even if a few extra people used it that were never going to be tobacco users or would have quit anyway, the extra harm would be small.

2. please outline your ethical basis for denying a person access to an alternative product that is

much less dangerous than the one they may be addicted to. You might think it will save the lives of others (I don't, and you can't show it will), but what about that person's individual rights? Do they count for nothing in the face of your bossy prescription?

3. please explain why it would be good policy to provide legal protection to the cigarette makers in the market for tobacco and a barrier to entry to potential competitors offering much lower risk products. This is an especially stupid idea now being aggressively pioneered by health campaigners in the United States through their seedy and desperate deal with tobacco giant Philip Morris to support a Bill to pass regulation of tobacco to the FDA. Expect many dead.

Read this instead...
For a decent review of the evidence, don't spend too long watching ASH Scotland struggle with basic epistemology. See Brad Rodu and Bill Godshall in *Harm Reduction Journal 2006, 3:37*; and the collection of 50 best papers on the International Harm Reduction Association tobacco section. Even tobacco companies provide better and more balanced analysis than this effort by ASH Scotland: see this account of Experience from Sweden by Swedish Match - or this literature review by United States Smokeless Tobacco.