

EDITORIALS

Electronic cigarettes as a method of tobacco control

Allow them, but research and monitoring are needed so that the risks can be regulated

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Electronic cigarettes (e-cigarettes), cigarette shaped products that vaporise nicotine in ways that enable it to be inhaled, have become increasingly popular in the past few years.¹⁻³ E-cigarettes are a potentially more attractive substitute for smoking than low toxin smokeless tobacco because the nicotine is delivered by puffing, as when smoking a cigarette. A range of products are now on the market, with new improved ones promised, and—something almost unheard of in tobacco use—self organising groups of users (who call themselves “vapers” because they inhale vapour, not smoke)—who are advocating for these products and sharing their experiences.¹⁻³ Opposition has come from some health groups, either for pragmatic reasons or because they are opposed to any recreational use of nicotine.

Medical journals including the *BMJ* have called for more research or regulation (or both),⁴⁻⁸ with the main difference being whether this should occur before allowing the products on to the market,⁴ or accepting that they might continue to be allowed.⁵⁻⁸

People who argue that research is needed first focus primarily on the risks—the lack of research on product safety and on the efficacy of e-cigarettes as cessation aids or as substitutes, and concern about them being a potential gateway to nicotine dependence for the young. These concerns have motivated some countries, such as Australia, to ban commercial sales.

Those who want them to be allowed now have focused on the potential of these products to serve as the centrepiece of a harm reduction strategy, with the argument being that e-cigarettes can drive down smoking faster than relying solely on a cessation oriented approach, because substitution is easier to achieve than abstinence. They also propose that these products cannot conceivably be as harmful as cigarettes and are probably much less harmful. They recognise that regulation will be needed to manage the risks, and that this will take time to work out because it is not appropriate to regulate these products as therapeutic goods.²

The United Kingdom and United States seem set to follow this more relaxed approach. A recent recommendation to this effect has come from the UK government’s behaviour insights team,⁹ a unit within the Cabinet Office. In the US, this approach has been forced by the courts recently ruling that e-cigarettes should be regulated as tobacco products because they make no

therapeutic claims and are thus subject to far less regulation before being marketed than would otherwise be the case.⁵

How should the arguments be weighed up? Safety concerns have been raised, but the bulk of products tested showed no evidence of acute problems with safety.² Clearly, all such products should comply with existing rules covering chemicals that are allowed for human consumption. It is not possible to predict what the long term effects might be, but—on the basis of research with other low toxicant nicotine products—the risks will probably be far lower than for smoked tobacco. It is also not known what proportion of smokers will use e-cigarettes rather than normal ones and what proportion will use them long term. The more e-cigarettes are used, the more smokers will be drawn away from smoking, but with the increased risk of substantial uptake by nicotine abstinent ex-smokers and those who have never used nicotine (mainly adolescents). Currently, there is no evidence of undesirable uptake, but it will be important to monitor trends so that action can be taken if it does occur. It will therefore be important to try to distinguish uptake in young people who would have smoked from uptake in those who would otherwise not have used nicotine.

The risk of undesirable use might rise if these products are marketed aggressively. This could happen if big consumer product companies were to buy into the market. These products should be subject to the same restrictions on advertising and promotion as other tobacco products, with changes (probably easing of restrictions) made only after careful consideration of the implications. That is not to say that no additional restrictions should be made now. A case can be made for controlling bulk sales of the nicotine solution on safety grounds,⁸ perhaps with the nicotine being sold only in ready to use cartridges.

Currently it seems that these products pose no serious immediate risk. On balance, by allowing the products to be sold the UK seems to be taking the approach with the greatest potential public health benefit. The approach also creates real incentives to conduct research and to consider more appropriate regulation. The alternative of waiting for the research may end up essentially as prohibition, if no one is sufficiently motivated to do the work.

However, allowing these products does not mean that health groups should actively promote them. Health professionals

should begin with evidence based strategies and promote these first. However, health professionals should be able to suggest to smokers who are unable or unwilling to use or continue to use effective aids to quit, and who are interested in e-cigarettes, that these are a better option than continuing to smoke. And although it is better not to use any form of nicotine long term, if patients must, e-cigarettes are a lower risk option than continuing to smoke.

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