Irresponsible and unaccountable: the BMA and its war on e-cigarettes

If only the bars were to protect us from them

A truly dreadful letter has appeared in the BMJ from two BMA committee members, Dr Chris Valentine and Dr Paul Nicholson, who write that Safety of e-cigarettes still needs to be proved and provide some terrible advice along with it that if acted on would cause more harm than it prevented. Valentine and Nicholson are respectively a member and the chair of BMA's influential Occupational Medicine Committee, and should approach their work with a great sense of responsibility and accountability. Sadly, they have neither. I have provided a rapid response to the BMJ, concentrating on the more philosophical failures apparent in this short letter. My rapid response (Safety of e-cigarettes still needs to be proved? BMA position needs to be challenged) is now published and reproduced below to allow for more expansive comment (with better formatting and fewer typos!).

> *There is so much wrong in such a short communication that it is hard to know where to start. I would like to draw out four types of error in this letter:*
>
> ***1. Framing errors.*** *The authors appear to misunderstand the concept of harm reduction. It is not necessary for e-cigarettes to be completely 'safe' – they just need to be very much safer than smoking, and not that dangerous in absolute terms for them to have a valuable public health impact if they function as an*

appealing alternative to smoking. If the BMA officials had studied the experience of snus (smokeless tobacco) in Scandinavia they would understand this concept. In fact, BMA was one of the organisations that wanted this product banned in the rest of Europe, prompting a number experts in the field to write to the Secretary of State for Health to voice their opposition to a ban with evidence [1]. There is a similar framing error in the authors' approach to acute toxicity of nicotine. Not only is their science obsolete and greatly overstates the toxicity [2] but their framing is wrong: we do not generally control toxic substances in the home by banning them or limiting container sizes to below sub-lethal doses: imagine having to buy bleach by the cupful. The approach taken is to classify, package and label the products appropriately – something that is easy to do, and the BMA could constructively support that instead of trying to reject the product outright on these spurious grounds.

2. Loss aversion and accountability for risks created by restrictive policies. *The authors appear oblivious to the risks that their own policy prescriptions might create. Many of the restrictions they favour, and their public relations line, will have the effect of denying these products to smokers or persuading them not to try the products – and this comes with consequences. A very much less risky product (e-cigarettes) than the dominant, highly dangerous, incumbent (cigarettes) comes to market and the medical establishment moves in to oppose it. Surely it is obvious that this risks protecting cigarette sales, increasing smoking, denying smokers options that might work for them, and so contribute to more disease and death. In their focus on small or implausible residual risks arising from e-cigarette use, these authors have not symmetrically accounted for the lost opportunities and risks that their ideas might create. I have set out a more detailed account of this argument and wish to remind the BMA that it should be accountable for additional preventable smoking that arises from its hostile position [3]. As an example, the authors make a wholly unsubstantiated claim that flavours are added to increase appeal children – there is no evidence at all for that. In fact, flavours are important to adults, and particularly important in supporting a long term move away from smoking. To ban flavours risks compromising the appeal of the product to the intended market (smokers) and so leading to more smoking than there otherwise would be. The authors give no reassurance that they have considered this risk, yet it is more plausibly significant in sign and magnitude than any risks they cite.*

3.Use of evidence in policymaking. *The authors want "long term data affirming lack of harm"… but one wonders what would satisfy them, and whether this is simply a tactic to create an insurmountable evidential hurdle? What should be done in the meantime? The British doctors survey that demonstrated the effects of smoking unfolded over 50 years [4]. To make good judgements about risks in public health, a physician has to look at all the evidence, weight it by its value, and where there is remaining uncertainty to consider the uncertain risks and potential benefits on an even footing. A good evidential picture can be developed starting from the basic physics and chemistry of the processes involved, the toxicology studies on liquids and vapours, the long established and well studied history of nicotine use where there is no tobacco combustion (i.e. in NRT and snus), the absence of significant reported ill-effects or serious incidents, and expert opinion. These all combine to suggest that the risks arising from e-cigarettes in general are low, and the risks of nicotine itself, while finite, are very low. Cherry picking single studies out of context does not alter that. They also misrepresent the evidence on whether these products are effective at smoking cessation. There is not just 'one study' showing these products to be effective in smoking cessation – there are several trials and impressive survey data. The survey for ASH for example, suggests some 700,000 current British e-cigarette users are now ex-smokers, whilst use among adolescents and non-smokers is very low [5]. Surely the BMA can extract some evidential value from that? What, on the other hand, are the implications of ignoring it?*

4. Missing humility and empathy*. I understand modern medical training includes listening skills and recognises the importance of empathy with patients. I would like to commend this approach to the BMA. It is quite possible that millions of smokers are finding something that works for them and gives them immediate gains in welfare and self-esteem and significant improvement in long term health and mortality prognosis – at least that's what many well-informed users say when they describe their experience. The tone from the BMA and the more reactionary elements of the health establishment is that the views and experience of users simply do not matter or are worthless anecdotes. I do not think this is right – not everything can be understood from RCTs and and thousands of user testimonies now point to huge welfare gains from this technology. I would advise any physician minded to take a dismissive view of e-cigarettes developments to look at some testimonies and remind themselves*

what the profession is all about. There are many available on the internet, and they make inspiring reading [6].

These issues have been raised before with the BMA and they have promised to consider them [7], but so far the organisation seems more concerned to defend its earlier positions, even though evidence and experience is increasingly leaving it looking scientifically vacuous, impervious to challenge and criticism and out of touch.

[1] Martin Jarvis, Peter Hajek, John Britton, Gerry Stimson, Riccardo Polosa, Karl Olov Fagerström, Michael Kunze, Karl Erik Lund, Jacques Le Houezec, Tony Axéll, Lars Ramström, Clive Bates. Letter to the Secretary of State for Health, Tobacco Products Directive and snus, 7 October 2013. Available online at: Why is the EU banning Europe's most effective anti-smoking strategy?

[2]Mayer B. How much nicotine kills a human? Tracing back the generally accepted lethal dose to dubious self-experiments in the nineteenth century. Arch Toxicol 2014;88:5–7. doi:10.1007/s00204-013-1127-0

*[3]Bates, C. Turning the tables on public health – let's talk about the risks *they* create? 3 July 2014*

[4]Doll R, Peto R, Boreham J, et al. Mortality in relation to smoking: 50 years' observations on male British doctors. BMJ 2004;328:1519. doi:10.1136/bmj.38142.554479.AE

[5]YouGov for Action on Smoking and Health Use of electronic cigarettes in Great Britain April 2014.

[6]See examples and links at: Bates C. Where is the humility? Where is the empathy? 30 December 2013.

[7]Bates C. Letter to Dr Vivienne Nathanson, 25 February 2014, Response from Dr Nathanson, 4 March 2014. Unable to take any more, I write to Dr Nathanson of the BMA. A similar challenge has been made by the campaign group Sense about Science What's the evidence for banning electronic cigarettes: we asked the BMA why they want them banned in public 12 December 2013

Update. I have now written to one of the authors enclosing this response

suggesting they prompt a rethink of the BMA position.

Dear Dr Valentine

I have seen your letter on e-cigarette safety published on the BMJ web site and I have to say I believe it is misguided and irresponsible, and that this stance will cause far more harm than it prevents. I have posted a rapid response to challenge these views and wanted to make sure you were able to consider at least this counter argument. I understand scientists who specialise in this field have also submitted a robust rapid response, and no doubt that will be published shortly. For convenience, I have enclosed my response at the end of this email and posted it on my Counterfactual blog: Irresponsible and unaccountable: the BMA and its war on e-cigarettes.

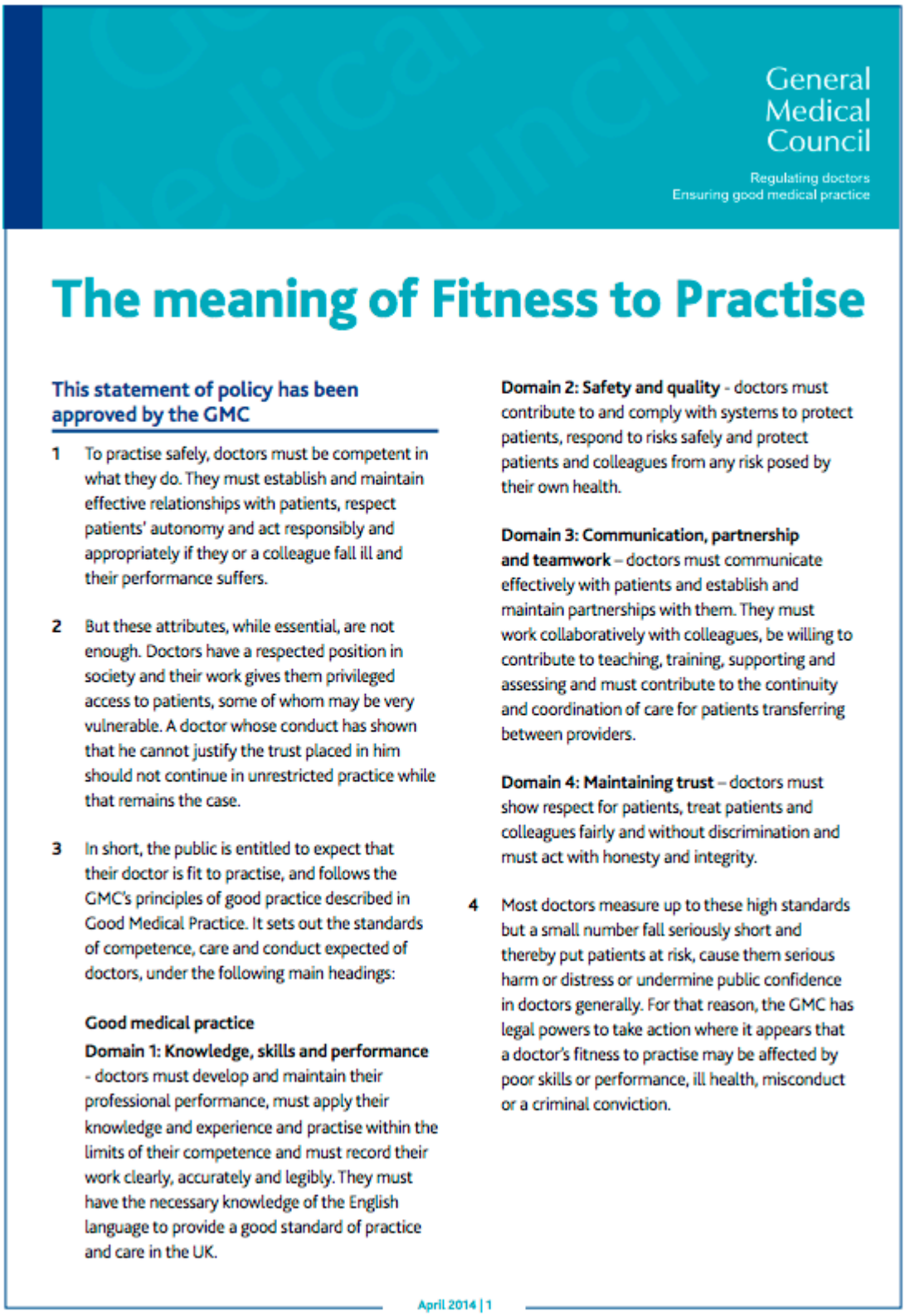
The reason to contact you directly is to suggest that BMA carefully and systematically reevaluates its position, which is now a long way out of alignment with the expert community and bodies that take a specialised interest such as ASH and the Royal College of Physicians. Failing that, I hope you will at least respond to the criticisms made by me and others. BMA statements wield considerable influence and authority, but the BMA does not seem willing to accept responsibility or accountability for the potentially harmful consequences of the positions it takes.<

I am copying in Prateek Buch of Sense About Science, a group that tries to equip people to make sense of the scientific assertions and evidence in public discourse. Sense About Science has repeatedly raised questions about the quality of BMA's evidence for the positions it holds on 'tobacco harm reduction' and e-cigarettes, but as yet has received no substantive response.

I would be grateful if you could share this with your co-author and committee chair, Dr Paul Nicholson, as I do not have an email address for him. I do hope you will seriously consider my suggestion for an in-depth review of BMA's approach to these issues.

Yours sincerely
Clive Bates
Counterfactual Consulting
Former Director Action on Smoking & Health 1997-2003
Note: no competing interests.

Update. I was asked if this can be taken to the General Medical Council. Actually, if the BMA and its officers actually followed GMC guidance on 'fitness to practice' they wouldn't be writing letters like this – and would have a lot more respect for their 'patients'. I guess handing out really bad advice and analysis to GPs is a bigger violation than just doing it in isolation unobserved in a GP surgery. See key page below:



General Medical Council

Regulating doctors
Ensuring good medical practice

The meaning of Fitness to Practise

This statement of policy has been approved by the GMC

1 To practise safely, doctors must be competent in what they do. They must establish and maintain effective relationships with patients, respect patients' autonomy and act responsibly and appropriately if they or a colleague fall ill and their performance suffers.

2 But these attributes, while essential, are not enough. Doctors have a respected position in society and their work gives them privileged access to patients, some of whom may be very vulnerable. A doctor whose conduct has shown that he cannot justify the trust placed in him should not continue in unrestricted practice while that remains the case.

3 In short, the public is entitled to expect that their doctor is fit to practise, and follows the GMC's principles of good practice described in Good Medical Practice. It sets out the standards of competence, care and conduct expected of doctors, under the following main headings:

Good medical practice

Domain 1: Knowledge, skills and performance - doctors must develop and maintain their professional performance, must apply their knowledge and experience and practise within the limits of their competence and must record their work clearly, accurately and legibly. They must have the necessary knowledge of the English language to provide a good standard of practice and care in the UK.

Domain 2: Safety and quality - doctors must contribute to and comply with systems to protect patients, respond to risks safely and protect patients and colleagues from any risk posed by their own health.

Domain 3: Communication, partnership and teamwork – doctors must communicate effectively with patients and establish and maintain partnerships with them. They must work collaboratively with colleagues, be willing to contribute to teaching, training, supporting and assessing and must contribute to the continuity and coordination of care for patients transferring between providers.

Domain 4: Maintaining trust – doctors must show respect for patients, treat patients and colleagues fairly and without discrimination and must act with honesty and integrity.

4 Most doctors measure up to these high standards but a small number fall seriously short and thereby put patients at risk, cause them serious harm or distress or undermine public confidence in doctors generally. For that reason, the GMC has legal powers to take action where it appears that a doctor's fitness to practise may be affected by poor skills or performance, ill health, misconduct or a criminal conviction.

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Update: more critical commentary is provided by Konstantinos Farsalinos and Riccardo Polosa in their excellent rapid response: Scientific evidence clearly indicates e-cigarettes are considerably less harmful than tobacco cigarettes.