Should Smokers be Advised to Cut Down as well as Quit? No.

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Should smokers be advised to cut down as well as quit?

Paul Aveyard and Nicola Lindson-Hawley say that reducing smoking is a worthwhile step towards cessation, but Gerard Hastings and Marisa de Andrade argue that the lifelong nicotine replacement therapy being recommended in support may benefit industry more than public health.

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Yes—Paul Aveyard and Nicola Lindson-Hawley

Currently, more than half of all smokers in England are trying to reduce the number of cigarettes that they smoke.¹ It seems perverse to discourage this positive behavioural change, but is it useful to encourage more smokers to cut down and to support those who do? We believe that it is.

Cutting down aids quitting

People who are cutting down are more likely to attempt to quit and to succeed than are those who are not cutting down.² This may be down to motivation to stop. People who are not cutting down are probably less motivated to stop than people who are. However, even when we take every possible step to adjust for differences in motivation, people who are cutting down are more likely to make a future quit attempt than people who are not.³ There are some good reasons why reduction might promote cessation. Nicotine addiction leads to neuroadaptation, and cutting down on smoking might reverse some of this, leading to less craving and withdrawal after stopping—the primary drivers of relapse.⁴ Reduction may weaken the conditioned response created by smoking, making relapse less likely to be triggered by exposure to cues to smoke after quitting. In addition, reduction is more similar than abstinence to the smoker’s current behaviour, and this could increase smokers’ confidence that they might succeed.

However, despite showing that reducers are more likely to quit than non-reducers, the evidence shows that people are not very successful at cutting down, with reducers smoking only about two cigarettes a day fewer than non-reducers.⁵ Teaching people methods to help them cut down seems to increase reduction and the chance of achieving cessation.⁶ There is little evidence that smokers are using behavioural methods of reduction, and the development of programmes and self help methods to assist reduction might lead to better outcomes than are currently achieved.

As well as behavioural methods, we might achieve a greater rate of cessation by encouraging reducers to use nicotine replacement. Randomised trials provide evidence that nicotine replacement therapy (NRT) can double the rate at which reducers eventually stop smoking.⁷ Many people and some doctors worry that nicotine itself is toxic, but any harm will be trivial compared with the harm that arises from smoking tobacco.⁸ As has been said, people smoke for the nicotine but die from the tar.⁹ Only a minority of people who are reducing use nicotine replacement.¹⁰ Greater promotion of smoking reduction and using nicotine for this would mean that more people stop smoking.

Stopping and reducing are not dichotomous

The argument against encouraging and supporting reduction is that it may divert smokers from stopping to reducing. This argument rests on the evidence that cutting down without stopping smoking does not reduce risk or improve health.¹¹ The fear of promoting cutting down as well as cessation is based on the belief that smokers may take the easy route of cutting down alone and not stop altogether. There is no evidence for this belief. People who are cutting down report that they are doing so mainly with a view to stopping completely.¹² When people who are trying to stop smoking are observed each day they cycle rapidly between trying to stop and trying to cut down,¹³ suggesting that cutting down and stopping are not the dichotomy that this debate presupposes. Even in people following formal programmes, those who follow a reduction programme before quitting and those who follow the traditional abrupt route have similar rates of quitting.¹⁴ We will never know what promoting reduction will achieve or risk unless we do it. However, formal modelling as well as the behaviour of smokers who cut down...
give us confidence that risks are low and the potential gains are great.  

Electronic cigarettes can support reduction, and the great increase in their popularity shows that people who smoke are keen to reduce and stop.  

compelling evidence that they [e-cigarettes] are any better than other cessation products; little is known about long-term use; there is worrying evidence about use by young people elsewhere; massive concern about tobacco industry involvement/promotion/normalising smoking . . . and, of course, in Australia we have made pretty good progress thus far [in reducing smoking prevalence] and we are looking for a further decline, especially with government committed to four successive years of substantial excise duty increases” (personal communication, 30 April 2014).  

The Australian strategy is core public health: cautious, evidence based, leery of disease vectors, and led by population level measures. The divergence from the UK strategy stems from a different characterisation of smoking, which is seen not just as a matter of individual dependence but as a social, political, and business phenomenon involving multiple vested interests—less a dyad between smoker and nicotine and more a danse macabre. Interestingly, as Daube’s remarks imply, Australia is doing very well—latest figures show that smoking prevalence there has dipped to 16.1%.  

Commercial exploitation of reduction  

This more complex view alerts us to potential hazards that lurk in the real world, beyond the consulting room and the randomised controlled trial. In particular, two corporate players come into focus: the pharmaceutical and tobacco industries.  

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onslaught of corporate capital in hot pursuit of a profitable opportunity.

In conclusion, any move away from tobacco by smokers is to be welcomed, and cutting down is no exception. However, smoking is about much more than nicotine addiction, and when addiction becomes overly dominant in the policy debate, as it now has in the UK, the principal beneficiaries are likely to be the multinational tobacco companies.

Competing interests: We have read and understood BMJ policy on declaration of interests and declare the following interests: PA has done occasional days of consultancy for McNeil and Pfizer on smoking cessation and was the chief investigator of a trial sponsored by McNeil. NL-H reports personal fees from manufacturers of smoking cessation aids and manages a National Institute for Health Research Health Technology Assessment funded trial of nicotine patch preloading. The nicotine patches for the trial are provided free of charge by GlaxoSmithKline (GSK). GSK has no other involvement in the trial.

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