Addiction

Note on the Symposium on Addiction, The Royal Society, London, 20th November 1987

The symposium was organised by Charter Clinics, and the director was Dr M R Trimble. Speakers were on a wide range of topics, including treatment of addiction and recovery. Most relevant to the tobacco industry, however, were presentations by Professor Anthony Clare of St. Bartholomew's Hospital, London (a well-known psychiatrist frequently in the media), Dr Martin Jarvis of the Institute of Psychiatry, London.

Professor Anthony Clare: "The Problem in Perspective".

Talking about what he considered to be the major drugs of addiction, Professor Clare put tobacco at the top of his list, and quoted a figure of 100,000 deaths per year. He believed that, because tobacco was a legally available drug, it ought to be considered along with alcohol and the psychotropics (valium, etc.) rather than with heroin.

Professor Clare mentioned that he had recently been at a meeting of the Health Education Authority at which he had raised the problem of maintaining education when industry was still advertising and trying to 'recruit new smokers'.

According to Professor Clare, smoking was "an intrinsically malignant form of drug dependence maintained by influence, wealth and vested interests". He mentioned that many MPs support the tobacco industry, and that the Health Promotion Research Trust was funded by the tobacco industry. He seriously doubted whether the tobacco industry should be allowed to sponsor such work.

Cannabis was mentioned in relation to tobacco and Professor Clare mentioned that its relative acceptability "may mask its own cancer of some kind".

Alcohol was viewed as the next most important 'drug addiction'. Professor Clare was supportive of the 1986 Royal College of Psychiatrists' report "Alcohol, our Favourite Drug" but was scathing about the recent similar report by the Royal College of Physicians, whom he described as living in the last century and still believing that if you frighten people to death they'll stop doing things. He believed that alcohol 'addiction' was a much more important question than cocaine and heroin addiction, and that media attention etc. was totally out of proportion.

During the discussion period, Professor Clare made the interesting point that people appear to enjoy tobacco and that if tobacco were taken away the question ought to be considered of what kind of substitute should be encouraged. He appeared to believe that nicotine per se was a relatively "socially innocuous" drug. During the same discussion, Professor Ghodse of St. George's Hospital, London, suggested that "you do not need syringes and needles if you have access from your lung to brain in seconds".

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Dr Martin Jarvis: "Addiction to Nicotine".

Dr Jarvis began by presenting some statistics on incidence of smoking, and said that because the majority of smokers are not giving up although they'd like to, they are therefore addicted. A study of smoking habits in Bristol secondary schools showed no evidence that smoking was about to go away. The predictors of taking up smoking were: having ever tried a cigarette, having ever been drunk, having a boy/girlfriend, thinking they'll smoke when they leave school, age, mother working, pocket money, whether their friends would mind and whether their teacher would mind. Parental smoking habits and social class were not predictive of smoking.

Dr Jarvis pointed to the following as evidence for nicotine 'dependence' in young smokers:

1. Nicotine intake per cigarette was similar to adults.
2. There was no increase in nicotine intake per cigarette with age (N.B. this would normally be considered to be clear evidence against an addiction hypothesis!).
3. The majority reported 'withdrawal' when trying to quit.
4. Cotinine levels appeared to predict 'withdrawal'.
5. 'Withdrawal' was associated with feelings of calmness when smoking.

Dr Jarvis said he would therefore disagree that smoking is a merely psychosocial behaviour at a young age.

Studies claiming to prove that smoking could be seen in terms of nicotine self-administration were presented. Dr Jarvis presented data comparing nicotine and cocaine on self-administration in animals (the animal in this case received one shot of nicotine or cocaine after a specific number of lever presses had been made). He claimed that nicotine was 'as addictive as cocaine' because similar levels of responding for the two drugs occurred. However, what Dr Jarvis failed to mention was the extremely important point that this kind of 'schedule of reinforcement' i.e. one dose of nicotine for many lever presses is the only on on which animals will work: if nicotine is available too frequently it appears to become aversive and animals stop pressing the lever. Cocaine, however, is self-administered under any and all circumstances. It was therefore extremely misleading to use, as an illustration of similarity, the only situation out of many in which the two compounds are similar!

A study in smokers was described in which smokers were deprived of smoking overnight. They then received a slow injection of either saline or nicotine over 1 hour, until they achieved plasma levels comparable to those had they been smoking. They were then allowed to smoke one cigarette. They noticed that the smokers who had received saline took sufficient nicotine from their first cigarette to bring them almost to the level of those who had received the nicotine; and that those who had received the nicotine did not increase their plasma levels after the first cigarette. Unfortunately, this was again extremely misleading use of data, since the people who had received the slow injection of nicotine were already close to a maximal obtainable nicotine level, and could not have been expected to increase much more. On the other hand, a smoker who had not smoked for a while would be bound to show a sudden increase in nicotine levels.

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The next topic was a brief mention of studies using nicotine chewing gum as an aid to smoking cessation. Although Dr Jarvis seemed to feel it was interesting that more people attempted to give up smoking if they had nicotine gum (61% with compared to 37% without) he failed to point out that the success rate 1 year later as a percentage of this figure was no higher.

The finale consisted of a brief discussion of passive smoking: measuring salivary cotinine in children and discovering that it increased from conditions of no parents smoking to only one parent smoking to both parents smoking. He seemed to be under the impression that the 1987 Surgeon General's report on passive smoking had concluded that ETS was a cause of disease, without qualification.

During the discussion Dr Jarvis expressed the opinion that tobacco companies should view themselves as drug companies. The RJR and Favor 'smokeless cigarette' - type products were mentioned; he did not appear to believe that nicotine toxicity would be a problem here. However, he said that it was unfortunate that most anti-smoking organisations are set against all forms of tobacco; he believed that 'safer' forms should be encouraged for those who will use it. His colleague, Michael Russell, has expressed similar views. The Chairman raised the interesting question of whether 'dependence' without damage to health was such a bad thing, and stated that 'caffeine dependence' was an example of 'addiction' without harm.

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cc Dr R E Thornton
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All members of the SRG

SB/LES/ADDICTION
18 December 1987

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BATCo document for Province of British Columbia 29 October 1999

BATCO 00094964