part that household and workplace restrictions play in promoting sustained smoking cessation, and by extension, reducing the exposure of children to secondhand smoke.[9 10] Other strategies, such as price increases, reduced availability of tobacco products, and mass media interventions, are also crucial.

As more is learnt about strategies to control tobacco and how they interact, it is clear that no one strategy will work alone. The indirect effects of a particular strategy may be just as important as the direct ones. The protection of children from passive smoking cannot be separated from the larger issue of reducing the harm caused by tobacco products in the population as a whole. The need for a comprehensive strategy to address this major public health problem is now readily apparent. The addition of these new studies strengthens the rationale for a comprehensive framework to protect children's health and prevent their recruitment to smoking in adolescence.

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Improving the treatment of tobacco dependence

Simple messages and an infrastructure to deliver them are needed

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Efforts to treat tobacco dependence are meant to supplement rather than to replace attempts to stop the tobacco industry's predatory recruitment of new smokers. Over 1.2 billion people worldwide regularly smoke tobacco products,[1] not including the use of roll-your-owns or smokeless tobacco. Reductions in numbers of deaths caused by tobacco over the next 50 years will depend largely on the success of tobacco users in breaking or controlling their addiction. Only in the second half of this century will our progress, such as it is, towards reducing the uptake of smoking among young people manifestly affect mortality.[2]

Three articles in this issue show the importance of smoking cessation or discuss the growing repertoire of effective pharmacological and behavioural approaches for treating nicotine dependence.[2–4] Their publication coincides with the 11th world conference on tobacco or health, which will focus on treatment issues such as quality, availability, and affordability.

There are some simple messages that clinicians can and should communicate to all patients. Firstly, don't smoke. Secondly, if you do smoke, there are major health benefits to stopping as soon as possible, no matter what your age or how long you have been smoking. Thirdly, a wide array of effective cessation treatments is now available.

Underscoring the health benefits of smoking cessation is the report by Doll et al based on a comparison of two case-control studies conducted 40 years apart in the United Kingdom (p 323).[2] They confirm that the risk of lung cancer has increased massively in smokers over this period and extend previous evidence of the substantial reduction in risk seen in people who stop smoking.[5] Even smokers who stop at 50 or 60 avoid much of their excess risk of developing lung cancer. The benefits of cessation become progressively greater with younger age of quitting.[2]

Also encouraging to both health providers and their patients is the wide array of effective smoking cessation treatments. Lancaster et al provide an up to date and comprehensive menu of treatments proved to be effective for smoking cessation (p 355).[3] Their overview is based on a Cochrane review and complements other recent reviews of cessation treatment,[6–9] including the guideline released by the US surgeon general in June (www.surgeongeneral.gov/tobacco/).[10]

Interesting but less certain are the long term implications of the randomised clinical trial by Bollinger et al (p 329).[4] Participants in the trial were adult smokers who had failed at least one previous attempt to stop smoking within the past 12 months. Smokers randomised to oral nicotine inhalers during the first four months of the trial reduced their cigarette consumption by over 50% per day during 24 months of follow up compared with smokers given a placebo inhalant. Several important questions are not answered by this trial, however. It remains unclear whether short and medium term reductions in the number of cigarettes smoked increase the likelihood of cessation. Either compensatory smoking—for example, more frequent puffing or deeper inhalation—or more prolonged smoking may offset the expected benefits of reducing the number of cigarettes smoked.[10] More research is needed to sort out the benefits and risks of strategies of "harm reduction" applied to smoking.[11–14]

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The infrastructure that would motivate clinicians to deliver these simple yet powerful messages to patients who are dependent on tobacco is woefully inadequate. About half of current smokers surveyed in the United States report that they have never been counselled to quit smoking by their doctors or other health professionals, even though over 70% of smokers visit a healthcare setting each year.[10] Patients who do successfully stop smoking say that counselling by their health provider provided important motivation.

Several measures could dramatically improve the availability and quality of medical treatment for tobacco dependence. Firstly, health systems and health insurance should cover counselling, pharmacological and behavioural interventions, and follow up for relapse. Secondly, physicians, health insurers, and policymakers must be educated that tobacco dependence is comparable to the addictive grip of opiates, amphetamines, and cocaine. Tobacco dependence is also a chronic relapsing condition: like other addictions and chronic diseases, it warrants repeated clinical intervention. An important challenge is to integrate the available, evidence based, and cost effective treatment of tobacco use and dependence into medical practice.

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The Engle verdicts and tobacco litigation

Incriminating documents drive the lawsuits, but destination remains uncertain

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It may be portentous that the $145bn in punitive damage verdicts against the American cigarette manufacturers were handed down by the jury in the Engle class action on 14 July.[1 2] The industry's lawyers alternatively characterised the verdicts as a mortal threat to the industry or as a legal chimera, certain to evaporate when tested on appeal. We will not know whether these verdicts were the tobacco industry's death knell until the Florida Supreme Court rules, perhaps two years from now.

The punitive awards for damages were actually the third round of verdicts that the Engle jury lobbed at the tobacco industry. A year earlier the jury found that cigarette smoking caused 20 diseases, and that the five cigarette manufacturer defendants, individually and in conspiracy with each other and two trade groups they had created, committed a variety of torts including fraud and fraudulent concealment. Then, in April 2000 the jury found the defendants liable to three individual class members, rejecting the industry's claim that two of them had a rare form of lung cancer not related to smoking and that the third developed his throat cancer from wood dust rather than his years of smoking. The jury awarded the plaintiffs compensatory damages for medical expenses, lost wages, and pain and suffering averaging more than $4m each. Extrapolated to the 500 000 or more ill or dead Florida smokers estimated to be in the class, the industry's obligation just to Florida smokers could conceivably exceed $2 trillion.

Unlike the tobacco industry's settlements with the states, which it can meet with annual payments averaging $10bn/year in perpetuity, legal judgments after jury verdicts are fully payable once appeals have been exhausted. Even so, if the industry's only legal liability were for the $145bn Engle punitive damage award, it could probably borrow the money to pay it off, financed by a modest price increase in its products.[3] But it certainly could not pay $2 trillion. More generally, compensating the 95% of Americans afflicted with disease caused by tobacco who are not Florida residents at just 10% of the rate adopted by the Engle jury in its individual verdicts would leave the industry with a multitrillion dollar liability that would mean bankruptcy.

Nor can Engle remain solely a Florida phenomenon. Unless Engle is quickly reversed, courts in other states will be called on to provide their residents with similar rights to recover from the tobacco industry. Indeed, in the week following the verdicts for punitive damages public health groups in Australia, Britain, and Canada publicly called for similar action in their countries, and the health minister of Italy proposed to sue cigarette manufacturers for damages to health.[4]

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