



FOR IMMEDIATE FREE RELEASE
Sunday, August 8, 2010
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Little communication in failed war against smoking

by John R. Polito

The war against America's leading cause of preventable death has ground to a standstill. Hundreds of millions of precious tax dollars spent trying to counter tobacco industry marketing, cigarette prices shooting through the roof, clean indoor air laws sweeping the nation, and still only a modest 23 to 21 percent decline in the adult smoking rate over the past decade. Now, a [new study](#) reports that agency turf wars and a lack of time kept key tobacco control government health officials from communicating with each other.

Eleven federal agencies within the U.S. Department of Health and Human Services (HHS) are charged with battling tobacco related dependency, disease and death. A just released study identified 54 tobacco policy, practice and research employees within those agencies as key tobacco control players. Forty-nine of them agreed to participate in the study's 2005 survey.

These 49 movers and shakers were questioned via e-mail about their communications and contacts within the HHS tobacco control network, and about barriers, if any, to effective inter-agency communication. Shockingly, some federal agencies reported little or no interaction with other agencies.

Picture America having 54 generals in a war that annually produces more than 400,000 deaths and, as reported by this study, 80% of our generals claiming that they don't have time to communicate with each other.

Tobacco network key employees at the Food and Drug Administration, which oversees quitting product approval, reported zero contacts with network employees within the other ten agencies. This despite [growing concerns](#) that use of placebo controls within nicotine replacement studies were not blind as claimed, and produced findings unworthy of belief.

The study also reported no inter-agency network contacts between the Centers for Medicare and Medicaid Services, which oversees payment for smoking cessation counseling. Additionally, extremely limited network interface was found at the Substance Abuse and Mental Health Services Administration, where the #1 objective is prevention of substance abuse.



According to the August [Tobacco & Nicotine Research](#) journal study, the Centers for Disease Control's (CDC) Office of Smoking and Health (OSH) is the most active agency in the war against smoking. What wasn't noted is that being active has not translated into effectiveness.

Among surveyed CDC network employees, 82% blamed failure to collaborate with other HHS agencies on a lack of time, 73% blamed bureaucracy, while 36% blamed inter-agency politics. Inside the National Institute of Health (NIH), home to the National Cancer Institute (NCI) and the National Institute on Drug Abuse (NIDA), 87% blamed time, 47% bureaucracy and 47% politics.

HHS's Failure to Protect Teens

The recent coal mining and Gulf drilling disasters suggest that when it comes to federal regulatory oversight that either the fox was in the hen house or the farmer was amazingly stupid. Sadly, in no hen house is the price of government ineptitude greater than in tobacco

control's.

Here, the tobacco and pharmaceutical industries appear to rely heavily upon health bureaucrat time constraints, communication isolation and inter-agency turf wars in preying upon youth immaturity and quitter ignorance.

Imagine President Obama being complicit in allowing [350,000](#) kids to become trapped below ground in coal mining disasters, the number of new daily youth smokers this year.

Picture [443,000](#) dead nicotine addicts floating face down in the Gulf of Mexico, with hundreds of toxin and carcinogen filled bodies daily washing up on Texas and Florida beaches, yet no Presidential press conference, and no Presidential butt kicking.

U.S. tobacco prevention and cessation policy is an ignored national disaster. In fairness, incompetent tobacco control leadership within HHS should have been fired long before Obama's arrival.

Even so, is it reasonable to expect a President whose brain is itself slave to nicotine to declare and vigorously prosecute war against those supplying his drug, or to dismiss incapable health bureaucrats who congratulate him on having successfully quit?

Claiming "[I am 95% cured](#)" while mixing intermittent smoking relapses with chronic nicotine gum use since [February 2007](#), arguably, no president in history has done more to muddy adolescent understanding of nicotine dependency than President Obama.

According to [Dr. Nora D. Volkow](#), Director of the National Institute on Drug Abuse - possibly HHS's boldest and brightest thinker - nicotine addiction is a permanent disease and mental illness for which there is no cure. And while the dependency can be fully arrested, the recovered addict remains subject to relapse for the balance of life.

The President's own ongoing struggle has been a golden yet missed opportunity to teach youth that nicotine is extremely addictive. Up to 26 percent of adolescents exhibit signs of loss of control over continued smoking after just 3 to 4 cigarettes, rising to 44 percent after 5 to 9.

Nicotine quickly activates, saturates and [desensitizes](#) brain dopamine pathway receptors, which is followed by growth and activation of millions of extra receptors, a nicotine tolerance re-wiring process known as [up-regulation](#).

A true "wanting" disorder that leaves the brain craving nicotine as though hungry or starving for food, nicotine dependency is as permanent as alcoholism, hijacks the same brain dopamine pathways as illegal drugs, and may be [harder to beat than heroin](#).

HHS's Failure to Insulate Youth

The tobacco industry spends roughly [\\$12 billion](#) annually to transform more than 140,000

neighborhood convenience stores into youth nicotine addiction traps. It knows that roughly two-thirds of teens are convenience store shoppers.

Most convenience stores make it impossible for a teen to purchase candy, chips or a soda without their subconscious mind being bombarded by scores of tobacco use invitations. A massive wall of brightly colored packs, cartons, cans, pouches and tubes all but wraps itself around them as they make their purchase. This contrived facade screams that tobacco use is normal, it's what adults do, it's flavorful and fun.

This intentional and well orchestrated assault repeatedly pounds home the message that the student has not yet tasted life's best flavors, experienced real excitement, felt true pleasure, made enough friends, worn spurs, taken sufficient risk, rebelled or looked adult, until they've experimented with smoked or oral tobacco.

Preying upon immature minds that can't wait for adulthood, the industry knows that up to 90% of new smokers start prior to age 20. It knows that unless it chemically enslaves them while young and gullible that profits will nose dive.

The industry wants adults to believe that the giant yellow "We Card" signs are there to alert students that the store checks I.D.'s. But once [secret tobacco industry documents](#) suggest that they are a tease, a constant and intentional reminder to children and teens that smoking is a rite of passage into adulthood.

Common sense suggests that the President's army of health officials should be joining forces, communicating and working overtime in support of national, state and local laws designed to insulate youth from these highly effective marketing traps. But it simply isn't happening.

The CDC's "[Best Practices for Comprehensive Tobacco Control Programs 2007](#)" is its cornerstone prevention policy document. Not once does this 122 page battle plan recommend passage of laws that would forbid youth under the age of eighteen from entering tobacco sales locations, nor suggest amendment of local zoning ordinances so as to require removal of exterior store tobacco marketing signs, signs bombarding young minds on passing school buses with destructive [subconscious subliminal tobacco use suggestion](#).

Instead of placing legislative barriers between youth and tobacco marketing, the CDC claims that the best way to protect students is to go toe-to-toe with industry advertising, by conducting expensive "counter-marketing strategies that employ a wide range of efforts, including paid television, radio, billboard, print, and web-based advertising at the state and local levels."

Under the CDC's slug it out policy, [26 percent](#) of high school 12th graders smoked cigarettes in 2003 and an identical 26 percent were smoking four years later in 2007.

The tobacco industry also has a sick history of purchasing cigarette placement and use in P and PG rated movies, with smoking by heroes in recent movies being 3 to 4 times more

likely than in real life.

The CDC's [website](#) warns that the average teen is exposed to 15 smoking scenes in moves per week. It declares that "a teen whose favorite star smokes is significantly more likely to be a smoker." The CDC then turns yellow and wimpish in failing to propose a solution.

The government could push for R ratings or at least demand parental disclosure of tobacco use in all movie advertising where any movie portrays smoking in a positive light. Instead, as with its failure to advocate insulating youth from store marketing, government health officials fear making waves.

Imagine going to work each day and staring into the face of a youth to grave nicotine addiction pipeline that annually kills hundred of thousands and then acting like cowards afraid to fight. America's youth might be better off being protected by General Electric, Colonel Sanders and Captain Crunch.

Yes, there would obviously be collateral economic damage associated with laws which exclude youth from entering tobacco sales locations. But whether recognized and wanted or not, the decision to sell what may be the planet's most addictive substance should compel serious reflection, and kids will not stop buying chips, soda or candy.

HHS's Failure to Help Smokers Quit

CDC and NIH admissions about not having enough time to coordinate battle planning becomes painfully visible when reviewing the accuracy of quit smoking advice presented on their joint quitting site [SmokeFree.gov](#).

While inter-agency communication data from the new study is now five years old (2005), SmokeFree.gov evidences how little things have changed and the degree of continuing pharmaceutical influence over these eleven federal agencies. The right hand not knowing what the left was doing, defenseless, easy, and isolated pickings have allowed industry influence to transform government quitting sites into online drug stores.

The #1 Internet quit smoking site, once there, smokers and quitters are bombarded with 173 invitations to use "medication." Although cold turkey will again this year produce more ex-smokers than all other quitting methods combined, not a single Smokefree.gov web page encourages, defends, promotes or teaches successful cold turkey quitting.

Pharmaceutical industry influence continues its stranglehold over Smokefree.gov's primary creator, the [Tobacco Control Research Branch](#)



(TCRB) of the National Cancer Institute (NCI).

The NCI either remained silent or was unaware that in 1999 the Agency for Healthcare Research and Quality (AHRQ) had appointed a panel of experts with [strong financial ties](#) to the pharmaceutical industry and charged it with rewriting official U.S. quitting policy.

The panel published its recommendations in June 2000. One recommendation consumed all others. "There are numerous effective medications for tobacco dependence," the [panel proclaimed](#), "and clinicians should encourage their use by all patients attempting to quit smoking."

With a single document, a single recommendation, the panel effectively outlawed all government assistance of cold turkey quitting. Competition silenced, tens of thousands of federal, state and local health employees were instantly transformed into "medication" salesmen, guaranteeing the pharmaceutical industry billions in profits.

How has the National Cancer Institute reacted? Today, it's the [#1 driver](#) of an Internet money train between smokers filled with carcinogen time-bombs and industry coffers filled with replacement nicotine receipts.

As the NCI is aware, and as President Obama can attest, replacement nicotine hooks a substantial percentage of quitters (up to [7% of nicotine gum users](#)), [elevates levels of the carcinogen NNN](#), promotes tumor growth and cell division via [angiogenesis](#), inhibits chemotherapy effectiveness by preventing natural cell death ([apoptosis](#)), and [accelerates the growth and spreading of cancer throughout the body](#).

Industry influence has so deeply infected all levels of HHS cessation thinking that there seems little hope of capping the well. How bad is it? During 2007 the NCI co-sponsored a [3 day industry sales conference](#) where the Who's Who of pharmaceutical industry consultants openly [advocated use of tobacco industry marketing tactics](#), in order to sell even greater quantities of replacement nicotine.

Imagine the insanity of teaching alcoholics that pharmaceutically sold replacement alcohol is "medicine" and its use "therapy." Thanks to a lack of nicotine dependency recovery understanding and effective leadership within the NCI and [CDC](#), that's exactly where [37.6 million](#) daily smokers now find themselves.

As noted by TCRB Chief [Cathy L. Backinger, PhD](#), "tobacco use remains the country's leading cause of premature, preventable death - including an estimated one-third of all cancer deaths." Still, TCRB staff members have continued to push replacement nicotine having strong cancer promotion ties, even as it watched the medication era bring decline in the U.S. smoking rate to a [standstill](#).

The question Dr. Backinger is hopefully asking herself is why Smokefree.gov continues to turn its back on the education and support needs of millions of cold turkey quitters. Are TCRB's cessation policy and quitting lessons responsible for an actual increase in smoking

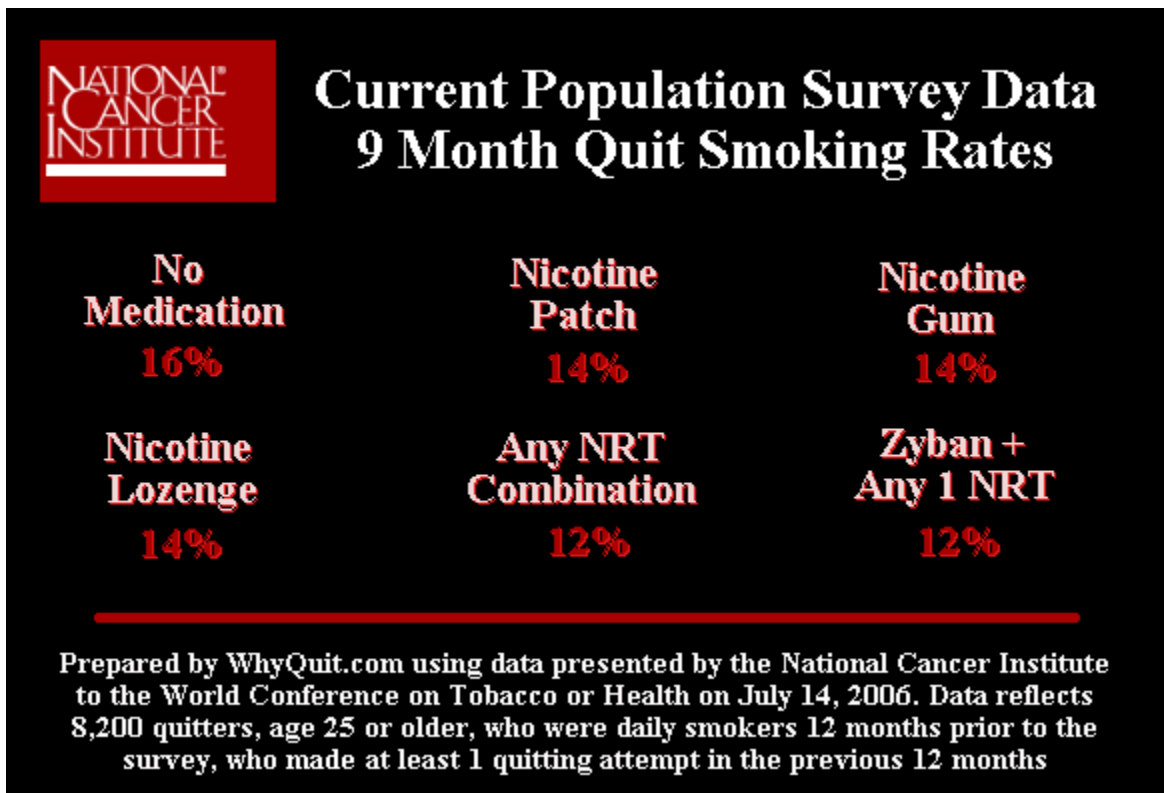
related cancers and disease? Does the National Cancer Institute share a degree of culpability in the cessation failures and deaths of thousands of smokers annually?

HHS Misrepresents "Your" Chances

Smokefree.gov's "[Medications to Help You Quit](#)" page states that "medicines can double your chances of quitting for good." Its "[Quit Guide](#)" again echoes that "medicines can double your chances of quitting for good." Its "[Dispelling Myths about Nicotine Replacement Therapy](#)" page continues the drum roll that, "NRT can double a smoker's chances of quitting smoking." And the chorus reaches crescendo inside the site's [Clearing the Air](#) quitting booklet which claims, "Studies show that these medications, compared with trying to quit without them, can double or triple your chances of quitting for good."

TCRB's double "your" chances campaign isn't limited to Smokefree.gov. Dr. Backinger presented a [Powerpoint presentation](#) in May 2007 claiming that, "pharmacotherapy can double the smoker's chance of quitting smoking." Why noteworthy? Because Dr. Backinger gave the presentation a year after a National Cancer Institute study found otherwise.

Far from doubling "your" chances, a 2006 NCI study found that those quitting without medications actually had slightly higher long-term success rates than those using medications. Yes, as horrible as this sounds, the NCI's Smokefree.gov website evidences what may be the most deadly government health deception ever.



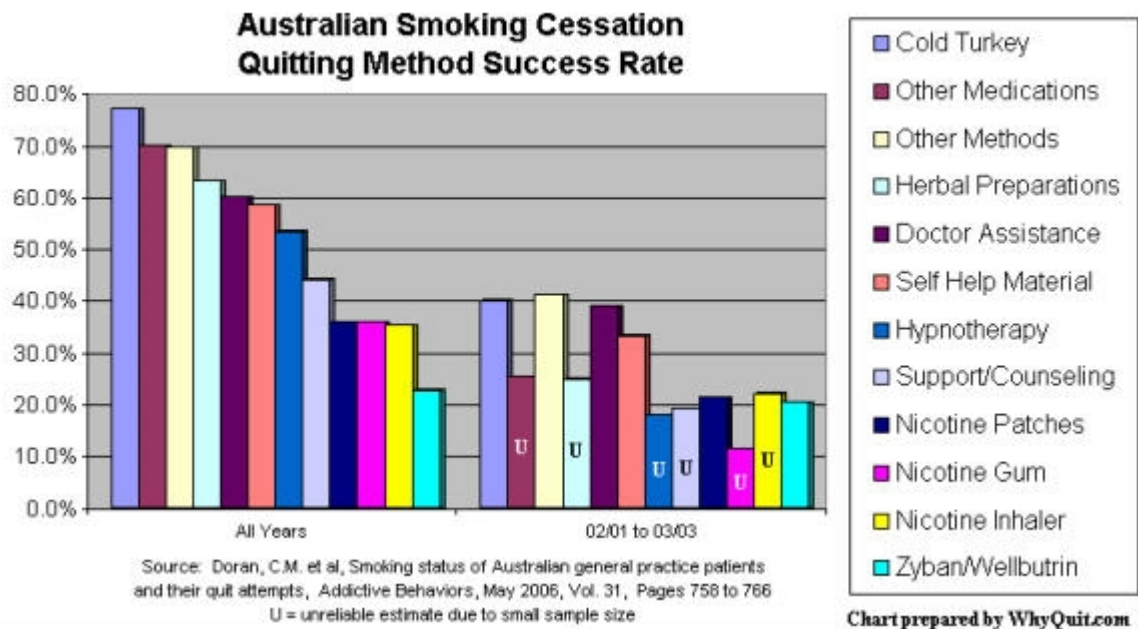
Pulitzer Prize winning journalist Kevin Helliker exposed the depth of pharmaceutical influence over HHS cessation policy in a 2007 front page Wall Street Journal article entitled, "[Nicotine Fix - Behind Antismoking Policy, Influence of Drug Industry.](#)" The story shared unpublished data from a June 2006 NCI survey of 8,200 quitters. The study found that 14% quitting without medication were still not smoking after nine months, compared to only 12% among nicotine patch, gum and lozenge users.

Obviously, "no medication" quitters include more than just cold turkey quitters. But prior surveys suggest that all but about 2% are either cold turkey quitters or smoking weaning/cut-down type quitters. Combined with [recent research](#), it suggests that roughly 70% of no medication quitters are cold turkey quitters. That same research also shows that cold turkey success rates are nearly double those of smokers engaged in weaning/reduction schemes. If true, the NCI's lumping together of weaning and cold turkey under "no medication" masks an even greater cold turkey victory.

Conclusion: "NRT appears no longer effective in increasing long-term successful cessation in California smokers."

Journal of the American Medical Association, Volume 288, Number 10, Pages 1260-1264, Sept. 11, 2002

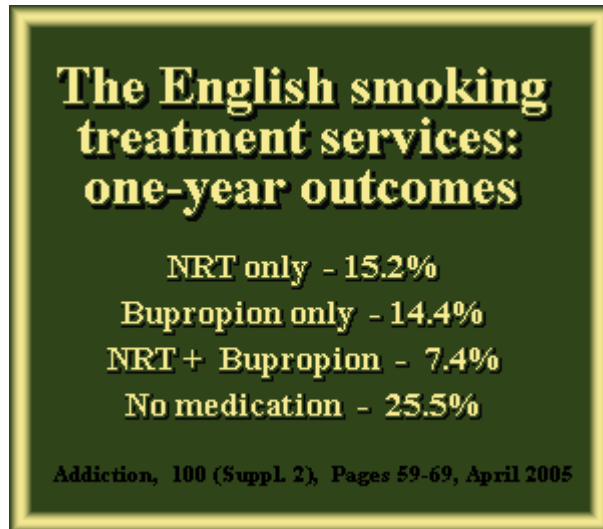
The National Cancer Institutes's real-world finding of medication failing to prevail over non-medication quitters is far from alone. Results of the world's largest smoking cessation survey were published in the September 2002 edition of the [Journal of the American Medical Association](#). It concluded that, "NRT appears no longer effective in increasing long-term successful cessation in California smokers."



A [2006 Australian study](#) followed the smoking patients of 1,000 family practice physicians. Not only did cold turkey success rates trounce medication quitters, the study found that cold turkey accounted for 1,942 of 2,207 former smokers, a whopping 88% of all success stories.

Surveys from Canada and London also show medication failing to prevail over cold turkey. The UK's national smoking treatment program offers what is likely the highest quality local counseling and support cessation programs of any nation. There, those quitting without medication have a 67% higher one-year success rate than NRT quitters, and a 77% higher rate than Zyban quitters.

Short term results (less than 6 months) are really rather meaningless when comparing cold turkey or "no medication" to "medication" success rates. When a study's medication use period lasts 3 months, at the 3 month mark the treated group is just beginning to attempt to live without chemical stimulation of brain dopamine pathways, while the placebo group's stimulation ended three months earlier. It's why such studies contrasting medication to no medication (placebo) inherently make medication appear 3 months better than reality.



While medications trounce placebo controls inside clinical trials, they fall flat on their face in real-world use. Why? While a number of factors play significant roles, the most profound is likely the fact that clinical trials pit medication quitters against quitters who joined seeking medication but didn't get it. It isn't until out in the real-world that medications are compelled to go head-to-head with real cold turkey quitters, quitters who fully expect to experience their withdrawal syndrome and successfully move beyond it.

The validity and scientific foundation of placebo-controlled cessation trials are rooted in the false assumption that these studies were blind, that participants were unable to determine whether or not they had been randomly assigned to receive an inert placebo or the quitting product being tested (NRT, Zyban, Chantix or NicVax).

Researchers knowingly introduce expectations bias by dangling [free quitting medicine](#) in front of smokers to entice study participation. Today, nearly all researchers are [aware](#) that it's impossible to hide the onset of full-blown nicotine withdrawal from those with significant quitting histories, quitters [expert](#) at recognizing nicotine's absence. While the gold standard in most study areas, use of placebo controls in drug addiction studies is [license to steal](#).

Experienced quitters randomly assigned to the placebo group should be expected to

recognize withdrawal within 24 to 48 hours of stopping smoking. Placebo controlled smoking cessation trials do not measure a product's relative worth (efficacy) but the satisfaction and frustration of expectations.

How bad is it? When asked to guess their assignment, three to four times as many assigned to placebo correctly guess placebo as guess wrong. A [recent study](#) by the nicotine patch's co-inventor reported that "of 165 subjects receiving placebo patches, 27 believed they had received active patches, 112 believed they had not, and 26 were unsure."

Name any other study area where those assigned to the placebo group are punished with the onset of significant anxieties and made vastly worse than when they arrived. Name any other study area where the condition sought to be treated (chemical withdrawal) is nonexistent until researchers command its onset ("ready, set, stop smoking nicotine").

It is normal to see 80% of the placebo group throw in the towel and relapse to smoking within the study's first week. If so, which group stands to benefit if the study has been designed to offer high quality once weekly counseling or group support?

Official U.S. cessation policy acknowledges that counseling and support are "[especially effective](#)," easily doubling or tripling cessation rates based upon the [amount of program contact time](#) and [number of sessions](#).

Pfizer's Chantix studies employed a record 25 counseling and support sessions. So how do we untangle Chantix's worth from counseling's? We can't. Amazingly, Pfizer's influence within the FDA was so great that the FDA approved Chantix (varenicline) without knowing its value as a stand-alone quitting aid.

"Population-based studies indicate that cold turkey cessation, not the use of NRT, is the most effective method for smoking cessation," [wrote Michael Siegel](#), a physician and professor at Boston University School of Public Health. "It is time for a serious re-examination of both the effectiveness of nicotine replacement therapy and the role of NRT as part of a national strategy for the promotion of smoking cessation."

HHS Actually Undermines Successful Cold Turkey Quitting

Obviously, HHS and Secretary Sebelius realize that no visitor to Smokefree.gov will be attempting to quit while chewing, wearing or swallowing a placebo. But the site's assault upon cold turkey quitting goes far beyond misrepresenting that "your" chances if quitting cold turkey are identical to the clinical trial placebo quitter who wanted medicine but didn't get it. HHS goes out of its way to undermine and damage smoker/quitter beliefs and confidence in their own natural recovery instincts.

The Cold Turkey section of the [Clearing the Air](#) booklet featured at Smokefree.gov states, "For some smokers, 'going cold turkey' seems like the easiest way to quit: Just stop smoking and tell yourself you'll never light up again. This works for some smokers - usually those with the lowest level of nicotine dependence - but not many. Fewer than 5

percent of smokers can quit this way."

Ask yourself, is it fair to assert that this booklet suggests that only 1 in 20 smokers have the ability to quit cold turkey? If so, there's simply no polite way to say this, it's a lie. Nothing could be further from the truth. As the TCRB staff is fully aware, every quitting method survey ever conducted evidences that the vast majority of all successful long-term ex-smokers quit smoking cold turkey.

Recently an [extended nicotine patch use study](#) made worldwide headlines. If on the TCRB staff ask yourself this, how many study participants who wore the nicotine patch for up to 6 months were able to stop smoking for one full year? Answer: [2 of 282](#) patch users, a horrible one-year continuous cessation rate of 0.7%, a rate seven times worse than the often cited "unassisted" cold turkey one-year rate of 5%.

Not once on any Smokefree.gov web page does the TCRB "clear the air" and tell the truth about how most smokers really quit. Frankly, it cannot allow the truth to be known. Why? Because it would totally undermine the backbone of the entire site, its 173 invitations to buy and use "medication" or "medicine."

Not once on any Smokefree.gov page are smokers told medications one-year quitting rate. Why? Because when NRT is used without counseling or support its 6-month failure rate is in the neighborhood of [93%](#), and the industry continues to treat 1-year stand-alone rates as if top secret.

Instead, the site's [Quitting Guide](#) tells 100% of visitors that "quitting 'cold turkey' isn't your only choice. Talk to your doctor about other ways to quit ... They can suggest medicine to help with withdrawal."

Another Smokefree.gov tactic that undermines successful non-medication quitting is telling all arriving smokers they should wait to quit, that "[your chances will be better if you get ready first](#)," that "quitting works best when you're prepared," that you should "set a date" and "talk to your doctor" about "medicine."

This "[Preparing to Quit](#)" advice is totally contrary to two recent studies which found that unplanned quitting attempts are twice as likely to succeed as planned ones. A [2006 UK study](#) taught the TCRB that "among respondents who had made a quit attempt between six

Table 3. Percent of Current and Former US Adult Smokers* Using Recommended Cessation Methods

	Current Smokers (%)*	Former Smokers (%)*
Followed recommended therapy (drug therapy and/or counseling)	15.1	6.8
Quit "cold turkey" or slowly decreased amount smoked	82.4	91.4
Other	2.5	2.1

*Weighted percents are age-adjusted; data for the analyses were derived from the National Health Interview Survey, 2000, National Center for Health Statistics, Centers for Disease Control and Prevention.

Source: American Cancer Society's "Cancer Facts and Figures 2003" report, Table 3, Page 25

months and five years previously the odds of success were 2.6 times higher in unplanned attempts than in planned attempts." This finding was duplicated in a [2009 study](#) (by acknowledged GlaxoSmithKline consultants, the maker of Nicorette gum), which found that "the odds of a 'spontaneous' quit attempt lasting for 6 months or longer were twice that of preplanned attempts."

Teaching nicotine addicts to wait and choose "[a special day](#)" such as "your birthday or wedding anniversary, New Year's Day, Independence Day, World No Tobacco Day (May 31) or The Great American Smokeout (the third Thursday of each November)" doubles their likelihood of failure.

Clearly, current medication use policies of both the NCI and CDC are well served by creating time to allow for its purchase. But telling a nicotine addict who is contemplating cessation to delay quitting both creates time for postponement excuses to arise ("things are just too stressful right now"), or for the gradual building and escalation of resolve destroying fears and anxieties, as they anticipate quitting day growing near.

The TCRB statement that "quitting works best when you prepare" is false. The question all HHS staffers need to ponder is, why this advice has been allowed to remain for more than a year after the second study, and how many successful quitting attempts the site's delay advice has cost.

Related SmokeFree.gov anxiety generating [advice](#) is that "Instead of smoking" ... "Think about something else." A [July 2010 study](#) reports that attempts at thought suppression actually increase unwanted thoughts, resulting in significantly more stress than when advised to think about and focus upon them.

Sadly, the site is filled with similar instances where the advice given is contrary to all known study evidence. What's heartbreaking is that no one within HHS appears to care.

HHS Hides Most Important Cold Turkey Lessons

While Smokefree.gov devotes 15 pages to teaching proper selection and use of medications, not a single page teaches corresponding concerns or critical lessons unique to successful abrupt nicotine cessation quitting.

For example, a critical cold turkey lesson is that nicotine is no longer acting as the quitter's spoon, that they need to eat breakfast, lunch and dinner or expect to suffer the consequences. Nicotine stimulates the body's fight or flight response, feeding smokers instant energy via release of stored fats and sugars. This allows smokers to develop a habit of skipping breakfast and even lunch without experiencing a host of [low blood sugar symptoms](#) that include cravings, anxiety, shakiness, confusion or difficulty concentrating, sweating, nervousness and weakness.

Cold turkey quitters benefit by knowing the importance of keeping blood sugar levels as stable as possible during early recovery, of eating healthy foods little and often, of not

skipping meals. Unless their diet or health prohibits it, they benefit by knowing the value of natural fruit juices prior to peak withdrawal (day 3), in helping stabilize blood sugars and diminish needless symptoms. Acidic [fruit juices also speed renal elimination](#) of the alkaloid nicotine from the bloodstream, allowing the possibility of brain receptor re-sensitization and down-regulation a bit sooner.

Clearly, this lesson is unnecessary for quitters using replacement nicotine. In fact, Smokefree.gov teaches NRT quitters the exact opposite, that they need to "wait a half hour after using the gum, lozenge, or inhaler before you eat or drink anything acidic. Acidic foods and drinks can keep nicotine gum and inhalers from working. Acidic foods and drinks include tomato sauce, tomatoes, oranges, lemons, grapefruit, coffee, soda, orange juice, and grapefruit juice."

So, why is there no corresponding page teaching cold turkey quitters the [value of acidic fruit juices](#) in stabilizing blood sugars and accelerating nicotine elimination? Examples of additional missing cold turkey lessons include normal nicotine elimination rates, when peak withdrawal is achieved, how nicotine's absence [doubles blood serum caffeine levels](#), the importance of being extremely careful with alcohol early on, cessation time distortion and crave episode duration.

But the most glaring Smokefree.gov absence is the "[Law of Addiction](#)," that "Administration of a drug to an addict will cause re-establishment of chemical dependence upon the addictive substance." HHS keeps hidden the science showing that just one puff of nicotine and [up to 50%](#) of the smoker's nicotinic-type acetylcholine receptors will become occupied by nicotine. While the majority of smokers walk away from relapse thinking that they succeeded in smoking just one, they soon find their brain begging for more.

Which of the following two statements are true? "Research shows that if you have even **one** cigarette after quitting, there is a 90% chance that you will return to regular smoking" or "Don't be discouraged if you slip up and smoke one or two cigarettes. It's not a lost cause. One cigarette is better than an entire pack"?

Shockingly, these conflicting lessons are found in different places on Smokefree.gov. The "90%" relapse quote is contained in a not so easy to locate brochure by Forever Free entitled "[What if You Have a Cigarette](#)." The "not a lost cause" contention is a featured segment in the site's [Quit Guide](#). It's as if the TCRB is unaware of the relapse research of [Brandon and Boreland](#).

Imagine advising an alcoholic not to get discouraged if you have a drink or two, or a heroin addict not to worry about shooting-up once or twice, that it's not a lost cause. Such advice may not be damaging to replacement nicotine users who have yet to stop using, but to a cold turkey quitter, who likely expended substantial resolve in breaking free from nicotine, it's an invitation to fail.

Pretend that you're a cold turkey quitter on day 4, now residing inside a nicotine-free body, yet fixated on the thought of smoking just one. Imagine visiting a government quitting site

that teaches you that smoking one or two cigarettes isn't a lost cause. How many lives is such advice costing? Sadly, HHS's handling of the most critical recovery lesson of all is so weak that it actually invites the recovering addict's mind to smoke and fail.

Teaching that lapse "is not a lost cause" defies nicotine dependency physiology. Withdrawal isn't a matter of choice or controlling discouragement but about brain function. Teaching nicotine addicts that they should be able to endure successive periods of the most challenging portion of recovery (withdrawal) is likely to result in creation of their greatest cessation defeat ever, causing fear, delay and postponement of future attempts.

Smokers need to be taught the truth, that just one puff of nicotine and relapse is all but assured. Instead, the TCRB sugar-coats and hides defeat behind the harmless word "slip," while sacrificing the greater good. Although full relapse following a "slip" is not 100% guaranteed, it's so close that the massive relapse prevention benefits flowing from having all quitters see, treat and act as though lapse equals relapse vastly exceeds the benefits of asking them to attempt to defy nicotine brain physiology.

Instead of teaching the secret to success, HHS teaches that it takes the average quitter multiple attempts before learning what it takes to quit and stay quit? Why not teach that if you take a puff you lose? Why not teach that all can succeed on their very first try, that there is only one rule that if followed provides a 100% guarantee of doing so ... no nicotine today!

Besides depriving cold turkey quitters of the most important quitting lesson of all, not a single Smokefree.gov page attempts to instill confidence in cold turkey quitting. Instead they attempt to get them to purchase "medicines," products that have already failed the vast majority of daily smokers.

Nearly three decades of quitting meds marketing has bombarded cold turkey quitters with the message that their odds of failure are double, that you have to be a super hero to succeed without meds. It's really rather amazing that most quitters continue to trust their own natural recovery instincts over the experts. What sense does it make to deprive such determination the encouragement, education and support needed to savor success?

Quitting cold turkey does not mean quitting in ignorance or darkness or without quality support. Nicotine is only a chemical with an IQ of zero. It cannot think, plan, plot or conspire, and is not some demon that dwells within. Although quitters will never be stronger than nicotine, they don't need to be. Their greatest weapon has always been their vastly superior intelligence but only if put to work.

What learning takes place by slapping on a patch, swallowing a pill, sucking a lozenge or chewing nicotine gum? HHS's fear of creating web pages that motivate, encourage, teach and support America's most productive quitting method is that visibly doing so will result in fewer quitters using "medication."

In other words, HHS intentionally ignores the cessation needs of the vast majority of

quitters in order to motivate use of products, which according to its own surveys are less effective in real-world use than quitting without them.

HHS's objective should be to make every visiting nicotine addict more dependency recovery intelligent than their addiction is strong.

This new agency interactions study found that inter-agency communication failures may be compromising the mission. While the authors were gentle, kind and stopped short of casting blame, there's abundant evidence that failure to communicate and coordinate in both protecting youth and assisting quitters is costing thousands of lives.

Although the study doesn't say it, if the primary purpose of the HHS tobacco control network is to provide entrenched health bureaucrats with job security then Congress needs to pull the funding plug. If HHS Secretary Kathleen Sebelius is serious about battling this nation's biggest killer, it cannot begin until she first addresses HHS's tobacco health leadership disaster.

Related Reading

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- Polito JR [Smokefree.gov really Buymeds.now](#), March 24, 2010
- Nitzkin, JL [American Association of Public Health Physicians Calls for End to Cold Turkey Discrimination](#), March 21, 2010
- Polito JR [CDC Ignores Cold Turkey Quitters](#), March 11, 2010
- Siegel M [New Study Shows That Even Extended Nicotine Replacement Therapy is Extremely Ineffective; Unaided Quitting Rates are Far Better](#), March 4, 2010
- Siegel M [Four Members of FDA Tobacco Products Scientific Advisory Committee Have Received Pharmaceutical Money; Influence of Industry on FDA Grows](#), March 2, 2010
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- Chapman S and MacKenzie R [The Global Research Neglect of Unassisted Smoking Cessation: Causes and Consequences](#), PLOS Medicine, February 2010
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Written August 8, 2010 and last updated August 11, 2010 at 0901 EST by [John R. Polito](#).