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Office of the Surgeon General
U.S. Department of Health and Human Services
200 Independence Ave., SW
Humphrey Bldg. Suite 701H
Washington, D.C. 20201

Dear Dr. Adams,

We have read with great interest your recent report, Facing Addiction in America: The Surgeon General's Spotlight on Opioids and would like to congratulate you on the publication of this thoughtful update and future strategy.

We advocate for harm reduction strategies to be applied alongside prevention strategies to further public health goals relating to risky behaviors, including opioid and tobacco use.

The harm reduction strategies discussed in your report can be broadly applied to populations that are *at risk* for misuse and abuse (for instance, those with chronic pain) or those that have already transitioned to dangerous opioid use.

We appreciated that this report acknowledges that no matter how a person may come to use or misuse opioids, it is important that harm reduction strategies are applied to prevent disease transmission and overdose death, facilitate recovery and improve quality of life. You, of course, are a leader in this field having quickly implemented syringe access programs in Scott County, Indiana to address an HIV epidemic among injection drug users in 2015.

It is with this in mind that we encourage you to apply the acceptance of opioid harm reduction programs to tobacco use and smoking. Your report explicitly states that "strategies to reduce the harms associated with opioid misuse and opioid use disorder have been developed as a way to engage people in treatment and to help preserve the life and health of those who are not ready to participate in treatment." Similarly, we know that when applied to smoking, harm reduction strategies can have a positive effect on the quality of life of smokers who cannot or do not wish to quit.

Unfortunately, the current trajectory of the FDA's agenda continues to put smokers at risk. Despite recognizing that tobacco products exist on a continuum of risk with combustible products (the most widely used) being the most dangerous, the FDA is now doubling down on efforts to prevent access to the products that we consider important in the context of harm reduction. Of course, both the Office of the Surgeon General and the FDA are aware of several

reports estimating that reduced-risk products like e-cigarettes exist on the opposite end of the spectrum—widely cited as *at least* 95% safer than combustible products (and many toxicological and epidemiological studies support this assertion), but recent actions indicate that the FDA will inappropriately disregard such information.

We agree with your concerns, and those of the FDA, that these products are not meant for kids. But as with all public health programs we must balance the known benefits with potential risks. There is good news in that adolescent smoking rates have decreased steadily over the last decade. It is our strong belief that tobacco harm reduction will benefit *all* cigarette smokers and serve as an off-ramp away from combustible use without serving as an on-ramp to combustible use.

You have stated that health officials (and therefore public health responses) must function within the culture and laws of their environment. We recognize this and are concerned that continued misinformation about tobacco harm reduction will, at best, discourage the 50 million smokers that live in the United States from switching to less harmful alternatives or, at worst, prevent these alternatives from being accessible to smokers.

The Office of the Surgeon General has a vital role in prioritizing and facilitating public health goals not only in the United States, but internationally. We ask that the Office expand the discussion of harm reduction efforts to include smoking and help to inform policymakers, and the public alike, about the role that harm reduction has in reducing the risks associated with smoking.

Sincerely,

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