Smoking, stigma and tobacco 'denormalization': Further reflections on the use of stigma as a public health tool

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Abstract

In recent years, addictions policy has stressed the need to counteract stigmatization in order to promote public health. However, as recent observers have noted, through the widespread implementation of tobacco 'denormalization' strategies, tobacco control advocates appear to have embraced the use of stigma as an explicit policy tool. In a recent article, Ronald Bayer argues that the mobilization of stigma may effectively reduce the prevalence of smoking behaviors linked to tobacco-related morbidity and mortality and is therefore not necessarily antithetical to public health goals (Bayer, R. (2008) Stigma and the ethics of public health: not can we but should we. *Social Science & Medicine*, 67, 463-472). This commentary takes up this question of whether stigmatizing smoking may ultimately serve the interests of public health. Through an examination of the unique contours of tobacco control policy, we suggest that stigmatizing smoking will not ultimately help to reduce smoking prevalence amongst disadvantaged smokers – who now represent the majority of tobacco users. Rather, it is likely to exacerbate health-related inequalities by limiting smokers' access to healthcare and inhibiting smoking cessation efforts in primary care settings.

Introduction

Over the past ten years, the strategy of 'denormalizing' tobacco use has become one of the cornerstones of the global tobacco control movement (see WHO, 2008). Tobacco denormalization "can be described as all the programs and actions undertaken to reinforce the fact that tobacco use is not a mainstream or normal activity in our society" (Lavack, 1999, p. 82). The concept has been used to capture a variety of policies and interventions that aim to influence social norms related to tobacco use, targeting tobacco products, the tobacco industry and smoking itself (Thrasher, 2006). Two specific types of strategies have increasingly been identified (Hammond, Fong, Zanna, Thrasher & Borland, 2006). Social denormalization strategies include limiting where smoking may take place, how tobacco products may be sold and advertised, and informing the public about the dangers of secondhand smoke through media campaigns (Lavack, 1999). Tobacco industry denormalization strategies, on the other hand, focus specifically on the tobacco industry and its conduct and seek to "raise people's awareness of the responsibility of the tobacco industry

for tobacco-related disease, and to expose the industry's manipulative tactics" (Hammond et al., 2006, pp. 225-6).

Although denormalization strategies underpin tobacco control at international, national and regional levels, recent observers (Bayer & Stuber, 2006; Bayer, 2008) have noted that these strategies have fostered a social transformation that appears to involve the active stigmatization of smokers, and therefore run counter to current approaches to other kinds of health-compromising substance use. In the context of other addictions, it has been argued that *de-stigmatising* drug use (use of alcohol, prescription, and illicit drugs) is crucial for encouraging timely access to healthcare and improving health status among people with addictions. Internationally, activities aimed at reducing addiction-related stigma have placed particular emphasis on reducing stigma to lessen barriers to a range of health services for people who use drugs and/or people with addictions.

The question of why tobacco control policy departs so radically from emerging public health orthodoxies regarding the need to counteract stigma, and whether such strategies are ever ethically justifiable, has recently been addressed in a special issue of *Social Science & Medicine* on stigma, prejudice, discrimination and health (volume 67, issue 3). This commentary adds to the discussion by focusing specifically of the distinctive contours of tobacco control policy and the likely impacts of denormalization strategies on health-related inequalities.

The distinctive dimensions of tobacco control policy

What explains the departure of tobacco control policy from responses to other addictions? Obviously, the most basic contrast between government responses to tobacco and illicit drugs is that the latter are subject to a general criminal prohibition whereas tobacco is a legal drug. Because criminal prohibition is premised on the moral assumption that the use of illicit substances is 'wrong' and the people who use them are 'bad' (Zimring, 1993), the stigma attached to illicit drug use is clearly apparent, and its negative consequences are well documented. However, tobacco, on the other hand, is a legal drug that was, until relatively recently, widely socially acceptable and commonly used. Thus, stigma has not been a historic concern regarding tobacco use. Indeed, denormalization policies seem to constitute an attempt to use stigma as an explicit tool to *replace* outright prohibition (see Zimring, 1993 for a discussion).

Also integral to the unique contours of tobacco control policy is the centrality of discourses focusing on the 'rights' of non-smokers not to be exposed to secondhand smoke (Goodin, 1989; Gusfield, 1993; Kagan & Vogel, 1993; Zimring, 1993; Berridge, 1999; Bayer & Colgrove, 2002). As Bayer and Colgrove (2002) note, the validity of the anti-smoking movement was cemented when it was able to align the issue of secondhand smoke to harms to 'innocent bystanders' such as children (see also Berridge, 1999). This allowed the anti-smoking lobby to further its claims whilst sidestepping accusations of paternalism (Bayer & Colgrove, 2002; Kagan & Vogel, 1993). By taking this approach, tobacco control advocates could therefore lobby for changes that would have been politically unpalatable if they had been pursued directly (Bayer & Colgrove, 2002, p. 953).

It is important to note that early efforts to restrict smoking (many of them successful) occurred within a context of scientific uncertainty about the precise nature of the harms of secondhand exposure to tobacco smoke (Zimring, 1993; Sullum, 1998; Berridge, 1999; Bayer & Colgrove, 2002). Indeed, examinations of the historical context of tobacco control policies in both the United Kingdom (Berridge, 1999) and Canada (Asbridge, 2004) have shown that policies and campaigns to restrict smoking were based less on scientific research than the issue of rights and the pressure placed on local municipalities by advocacy groups. However, the medical legitimacy provided by research findings on the health impacts of passive smoking allowed tobacco control advocates to redefine passive smoking from a moral and rights-based issue into a medical and scientific one – although "this was a scientific issue where self-regulation and individual morality were still central" (Berridge, 1999, p. 1192). Indeed, as several commentators (e.g., Klein, 1993; Sullum, 1998) have noted, tobacco control advocacy has historically had many of the characteristics of a moral crusade.

Recent debates about tobacco denormalization

Despite the conflation of medicine and morality that has historically underwritten tobacco control advocacy and action, few scholars have explored the ethical implications of tobacco control policies that implicitly endorse tobacco-related stigma. In a recent article, Bayer (2008) asks important questions about the use of such strategies:

> If the state may legitimately shape or control behaviors that increase the risk of disease and death by the exercise of explicitly coercive measures, if it can undertake health promotion campaigns that seek to change social norms and individual preferences, even desires, should it be permitted to adopt strategies that will incidentally but unavoidably stigmatise behaviors that pose a threat to the public health? May it engage in efforts that have as their intended goal the stigmatization of such behaviors through campaigns that attempt to tap the power of shame and guilt to affect social norms? (p. 468).

For Bayer (2008), the central question relates to the effectiveness of stigma in reducing smoking prevalence, and he cites several cross-sectional studies that smoking-related stigma has been effective in reducing cigarette consumption and smoking prevalence at a broader population level (Kim & Shanahan, 2003; Hammond et al., 2006; Alamar & Glantz, 2006). Bayer's conclusion seems to be that if stigmatization (especially stigma that is temporary and has as its goal the reintegration of those shamed) is instrumental in changing "pathogenic" patterns of behavior then it may be morally acceptable to foster it to reduce the burdens of smoking-related morbidity and mortality.

Burris (2008), in a response to Bayer's (2008) article, takes exception to the idea that the state can ever implement or foster stigma in an ethical way. In his view, by definition stigma is an "arbitrary and cruel form of social control (p. 475) and he cites Martha Nussbaum's position that liberal societies should not be in the business of shaming their citizens. However, Burris (2002, 2008) is unconvinced that tobacco denormalization actually fits the "decentralized and visceral mode of social control" (Burris, 2008, p. 475) that characterizes stigma. He therefore concludes that it is necessary to watch for signs that smokers are becoming social pariahs, are being stereotyped or suffering status loss or are beginning to internalize negative social attitudes and punish themselves. He adds that policy makers should be particularly careful of

the risk that public health efforts will add fuel to existing stigmas of minority group or classes.

Burris' (2008) cautionary words about the potential for public health efforts to further stigmatize certain groups hold particular relevance for tobacco policy. Over the last thirty years, the prevalence of smoking has dropped across all sectors of society. However, the prevalence of smoking among higher income groups has dropped more rapidly than in lower income groups (Kaiserman, 2002; Killoran, Owen & Bauld, 2006). Thus, smoking is now most prevalent in lower socio-economic status (SES) groups (Burns & Warner, 2003; Jarvis, Wardle, Waller & Owen, 2003; Killoran, Owen & Bauld, 2006; Bayer & Stuber, 2006).

As a result of these changes in the social composition of smoking, the strategy of tobacco denormalization by implication focuses on the most socially vulnerable: "the poor who continue to smoke" (Bayer & Stuber, 2006, p. 49). In Bayer's (2008) view, it is precisely the social gradient in smoking that may help to justify the moral acceptability of stigmatizing smokers. According to Bayer, the burden of denormalization policy interventions imposed on an already socially vulnerable and marginalized sub-population is justified by appeal to the net benefits to that population. Since the subpopulation in question has the highest incidence of tobacco-related disease (Gruer, Hart, Gordon & Watt, 2009), this subgroup also stands to benefit disproportionately from the intervention. For Bayer, then, the short-term inequities caused by denormalization policies that implicitly foster class-based stigma are justified by longer-term improvements in the health of working class smokers. His position can therefore be firmly located within the field of public health ethics – a discipline centrally concerned with the conditions under which individual freedom can be overridden for the sake of public health (Buchanan, 2008).

Denormalization as a panacea for smoking-related health inequalities? Some cautionary thoughts

Although Bayer (2008) argues that the short-term inequities caused by denormalization policies may ultimately lead to longer-term reductions in tobacco-related health inequalities, the history of tobacco control policy does not provide cause for optimism. Tobacco control policies have historically acted to widen health inequalities by having a greater impact on the better off (Killoran, Owen & Bauld, 2006; Barnett, Moon & Kearns, 2004). Smoking policies and cessation programs have yielded less success among lower income groups and a UK study found that regardless of living in regions that were targets for stop smoking services, cessation rates were still lower among working class groups than white collar workers (Bauld, Judge & Platt, 2007).

Entrenched smoking behaviors are connected with higher levels of nicotine dependence, psychiatric diagnoses, pleasure and enjoyment from smoking, rejection of social pressures to quit among smokers and age in lower SES groups (Burns & Warner, 2003; Jarvis et al., 2003). Research with "hardcore" smokers has shown that they are more likely to be older, male and disproportionately concentrated amongst economically disadvantaged and lower income groups (MacIntosh & Coleman, 2006). Indeed, it is precisely the changing social composition of smoking that has been integral to its transformation into a deviant and marginalized behavior. Several scholars (Zimring, 1993; Berridge, 1999; Bayer & Colgrove,

2002) have noted that it was only when tobacco consumption became concentrated amongst those of lower socioeconomic status that nonsmokers' rights groups were able to mount a successful attack on the substance and it became easier to stigmatize as an undesirable behavior. Zimring (1993. p. 99) labels this a "trickle-down" pattern of desistance which "invites the attachment of moral stigma to the residue of the population that continues to use" the substance.

Thus, denormalization policies have the effect of sanctioning stigma implicitly directed towards a particular segment of the population: the segment with least ability and/or willingness to quit. That such policies are likely to most detrimentally affect low income, "hardcore" smokers is overtly recognized in California's influential denormalization strategy, which has as its explicit goal the transformation of social norms around smoking to the point that tobacco use might be "contained" to a "shrinking pool of aging, hardcore users" (California Department of Health Services 1998, p. 4).

However, interestingly, the limited available evidence indicates that less educated, lower income smokers perceive less social denormalization (Hammond et al., 2006) and smoker-related stigma (Stuber, Galea & Link, 2008) than more educated and higher income smokers and that it consequently has less impact on their smoking patterns. Thompson, Pearce and Barnett's (2007) New Zealand research provides a potential explanation for this apparent discrepancy. They have argued that smoking-related stigma may conversely help to reinforce "smoking islands" – socio-spatial environments in which smoking is more accepted, either because of a sense of active resistance on the part of disadvantaged smokers, or a sense of helplessness in their ability to quit. Such findings point to the likely iatrogenic effects of denormalization policies – which, we believe, go well beyond the reinforcement of a smoking identity amongst low-income smokers.

First, the stigma currently attached to smoking appears to be partially responsible for efforts to frame health care as a privilege that smokers have negated the 'right' to access. Recent media reports from Canada (Kohler & Righton, 2006), the UK (Hall, 2005) and Australia (ABC News, 2007) indicate that some surgeons are refusing to treat smokers or are pushing them down surgery waiting lists, and more doctors are turning smokers away from family practice clinics. The doctors who have taken such steps point to the growing demands placed on GPs in a health care system where supply does not meet demand and resources are already spread too thin and, increasingly, smokers' right to self-determination is seen to conflict with other principles central to medical ethics such as beneficence and fair distribution of resources (Bremberg, Nilstun, Kovac & Zwitter, 2003).

Although such reports are anecdotal, there is more evidence of widespread discrimination against smokers in the Canadian and US healthcare systems. A survey of more than 250 physicians from across Canada found that up to 25% of doctors admitted to discriminating against smokers in terms of quality of health care, responding in the affirmative to questions such as: 'Have you refused treatment because a patient is a smoker?' and 'Have you provided treatment that may not have been as thorough because the patient is a smoker?' (Canadian Lung Association, 2005). Similarly, a US study (Barr, Celli, Martinez, Ries, Rennard, Sciurba et al., 2005) found that 83% of physicians thought that COPD was a "self-inflicted"

disease and a significant minority were nihilistic about the treatment of patients who continued to smoke. Smokers themselves report discriminatory treatment from healthcare professionals (e.g. McKie, Laurier, Taylor & Lennox, 2003) and those with symptoms of smoking-related diseases such as lung cancer and COPD are likely to delay seeking care because of concerns about smoking-related stigma (Corner, Hopkinson & Roffe, 2006; Tod, Craven & Allmark, 2008; Gysels & Higginson, 2008).

These attitudes and practices illustrate how successful denormalization efforts have been in changing social norms, values and attitudes regarding smoking and smokers, although they also speak to broader cultural transformations that increasingly situate the problem of health and disease at the level of the individual (see Petersen, 1997; Lupton, 1995; Petersen & Lupton, 1997). In this context, 'lifestyle-induced' risk factors such as smoking, overeating and physical inactivity are reduced to the level of individual responsibility and the patient's perceived unwillingness to modify these behaviors (Kohler & Righton, 2006). It is not only smokers who bear the brunt of such views; there is evidence that healthcare professionals hold negative and stigmatizing attitudes towards people who are overweight (see Oberrieder, Walker, Monroe & Adeyanju, 1995; Teachman & Brownell, 2001; Ferraro & Holland, 2002; Anderson & Wadden, 2004). However, while doctors are able to discriminate against overweight patients, it is only in the context of smoking that they are given implicit sanction to do so. The likely class-based consequences of limiting smokers' access to care have not received adequate consideration in discussions to date of the ethics of tobacco control policy.

Ironically, denormalization policies may also serve to further cement health inequalities by inhibiting discussion about smoking cessation in primary care settings. Recent research (Stuber & Galea, 2009) indicates smokers who perceive high levels of smoking-related stigma are more likely to keep their smoking status a secret from their healthcare providers. For their part, doctors who are sympathetic to smokers and would like to offer smoking cessation support in a sensitive way may be inhibited from doing so because of the charged environment denormalization policies have created around the issue of smoking. Indeed, one study (Bremberg et al., 2003) found that doctors who were concerned about enhancing the doctor-patient relationship were less likely to raise the topic of smoking cessation. Similarly, another group of GPs cited fear of harming the doctor-patient relationship as a frequent barrier to discussing smoking with patients (Coleman, Murphy & Cheater, 2000). Such concerns are only likely to intensify in the increasingly charged environment denormalization policies have created. Clearly, as these impacts of stigma have been well documented in the area of other addictions, the lessons learned from the field of addictions regarding the relationship between stigma and barriers to healthcare appear equally likely to apply to the field of tobacco control.

Conclusions

Although tobacco denormalization strategies have become increasingly popular in the field of tobacco control, in light of the growing consensus in addictions policy and research regarding the detrimental impacts of stigma on access to healthcare, further scrutiny needs to be placed on the use of such strategies as a public health tool. Historically, tobacco control policies have acted to entrench class-based health inequalities and there is no substantive evidence to suggest that denormalization strategies will serve to reduce these inequalities. Indeed, they

are likely to exacerbate them because they enable a political environment in which healthcare is increasingly seen as a privilege that smokers have negated the 'right' to access. Ironically, they are also likely to inhibit smoking cessation efforts in primary care efforts due to increased nondisclosure of smoking status and physicians' concerns about their ability to deliver effective support regarding this charged issue.

Ultimately, it is imperative that ethicists move beyond rights-based discourses centered on the limits to individual liberty and stress the importance of providing for the well-being of those particular populations, typically vulnerable and marginalized groups, who shoulder an unequal share of the burden to promote public health (Kayman & Ablorh-Odjidja, 2006; Baylis, Kenny & Sherwin, 2008; Bellagio Group, 2007). As Baylis, Kenny and Sherwin (2008) argue, public health policy makers have a responsibility to secure fair process, equity, build mutual trust and solidarity, and ensure reciprocity in meeting public health goals as well as attend explicitly to the unique needs of vulnerable populations. To date, these responsibilities have received little consideration amongst tobacco control policy makers and the voices of those affected by tobacco control policies (primarily people who are already socially and economically disadvantaged) are largely absent from policy-level discussions and decisions.

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