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# No Smoking

## THE ETHICAL ISSUES

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challenged by evidence of the addictive nature of nicotine, making it difficult for smokers to start and stop at will.

These new developments make smoking a paradigm of another kind: an issue concerning the quality of social life, requiring codes that are formal rather than informal and enforceable rather than merely hortatory. Here, morally worthy goals cannot be achieved if backed by morals alone. Legislation is not only permissible but, in some ways, morally mandated.

In arguing toward those conclusions, I shall organize my discussion along Mill's classic lines. First I shall discuss "harm to self" that occurs as a result of smoking, and to what extent that justifies social intervention. Next I shall discuss "harm to others," and the extent to which that justifies social intervention. Finally I take up various arguments and counterarguments that arise in connection with those various proposals for social intervention. Although of special relevance for the ethics of smoking and its control, many of those issues recur in a wide range of other applications as well. Indeed, my own past experience suggests that the best way to discover general principles of very broad applicability is through an in-depth examination of some particular policy puzzle.[6]

6. The importance of the general principle of "protecting the vulnerable" first struck me in connection with the ethics of nuclear power generation (Goodin 1980, pp. 438–39); those two pages subsequently grew into a book (Goodin 1985).

# 2 Harm to Self

The first and most obvious reason we may have for wanting to restrict smoking is to prevent harms that would be done to smokers themselves by their smoking. This chapter opens with a survey of those harms and of the scientific problems in assessing them (section 2.1).

Of course, Mill and his followers would query whether "his own good, either physical or moral" is ever "sufficient warrant" for coercively interfering with a person's own behavior. But they would be the first to concede that it might be, if the behavior is not fully voluntary. If it is autonomy that we are trying to protect in opposing paternalistic legislation in general, then the same values that lead us to oppose such legislation in general will lead us to welcome it in those particular cases where what we are being protected from is something that would deprive us of the capacity for autonomous choice. Evidence of the addictiveness of nicotine, surveyed in section 2.2, suggests that even advocates of personal autonomy ought to favor smoking restrictions on those grounds.

Another class of broadly utilitarian moral theories would have us look instead to people's welfare, both individually and especially collectively. Although it turns out to be a slightly longer story than one might first imagine, that too would lead us to favor restrictions on smoking, as shown in section 2.3.

In pursuing these goals, we face a choice among several broad styles of policy. They range from "self-regulation" on the part of the tobacco industry, or "self-help" on the part of injured smokers initiating tort damage suits, through government bans on the advertising, sale, or use of tobacco products. By and large, the arguments canvased above offer slender grounds for any principled choice among those options, advising merely that we should choose whichever policy works best to achieve the stipulated goal. In section 2.4, I survey such evidence as we have on the track records of various

alternative policies for restricting tobacco consumption, and I tentatively propose my own preferred policy mix on the basis of that survey.

## 2.1 WHAT ARE THE RISKS?

Folk wisdom has long held tobacco smoking to be unhealthy. During the first outbreak of the smoking epidemic in the seventeenth century, the authorities tried to outlaw it on grounds of public health (Harrison 1986, p. 555). From the earliest days of our own century, cigarettes have been popularly known as "coffin nails," everyone's grandmother warned that they would stunt your growth, and so on.

Proper medical evidence scientifically supporting such suspicions began mushrooming in the 1950s and culminated in the justly famous reports of the Royal College of Physicians of 1962 and of the U.S. surgeon general two years later. The subsequent scientific literature on smoking and health—now numbering over 50,000 studies (U.S. Department of Health and Human Services [DHHS] 1986, p. vii)—has merely served to reinforce those earlier fears.

The easiest way into this vast technical literature is through the surgeon general's reports: *Smoking and Health* (U.S. Department of Health, Education and Welfare [DHEW] 1964); the series on *The Health Consequences of Smoking*, published almost annually since 1967 and focusing on a different hazard each year; and consolidation volumes in that series (U.S. DHEW 1976; U.S. DHHS 1989). These reports contain both nontechnical summaries for the general reader and fuller summaries of technical literature for anyone wanting to follow up in some detail; to follow them up further, see the U.S. DHHS annotated bibliography, *Smoking and Health Bulletin*, published six times a year and collected annually as the *Bibliography on Smoking and Health*. The Royal College of Physicians reports (1962, 1971, 1983) are more sporadic but aimed more at a mass audience.[1]

In a way, though, further reading is not really necessary. The basic findings are familiar enough already. Smoking leads to cancer (especially of the lung and respiratory tract, but also of the pancreas and bladder) and to cardiovascular diseases (particularly coronary heart disease, but also peripheral vascular disease) and is the major cause of chronic obstructive lung disease.

If the basic findings are familiar, the magnitude of the effects can still shock. To say that smoking is responsible for more than 350,000 deaths per year in the United States is to say that about 15 percent of all deaths in the United States are smoking-related (U.S. DHHS 1986, pp. vii, 5–6). Put in more personal terms, "about a quarter of the young men who smoke a pack a day or so of cigarettes are killed

1. The best single brief article is Fielding (1985).



before their time by smoking"; and "on average . . . [they] have lost ten to fifteen years of life" (Peto 1980, p. 45).

Another way of putting the point is in terms of age-adjusted mortality rates. Of course, the older you are the more likely you are to die over the course of the next year. But factoring out age considerations, the point remains that at any given age smokers are 68 percent more likely to die over the course of the next year than are nonsmokers; and age-adjusted mortality rates for heavy smokers are about double that. In terms of such age-adjusted mortality rates, a moderate smoker's chances of dying from lung cancer are 10.8 times greater than a nonsmoker's; of bronchitis or emphysema, 6.1 times greater; of cancer of the larynx, 5.4 times greater; or oral cancer, 4.1 times greater; of cancer of the esophagus, 3.4 times greater; of coronary artery disease or other heart diseases, 1.7 times greater; and so on down the list (U.S. DHEW 1964, p. 29).[2]

Such findings have been confirmed time and again in subsequent replications of those early studies. The surgeon general's annual reports on this unfolding literature make drearily monotonous reading.[3] The surgeon general has, accordingly, concluded repeatedly that "cigarette smoking is the largest single preventable cause of death and disability for the U.S. population" (U.S. DHHS 1986, pp. 5–6). And even President Reagan's Council of Economic Advisers [U.S. CEA] 1987, p. 184) was forced to agree: "smoking presents the largest single source of health risk in America."

In principle, the advent of low tar and nicotine cigarettes might have been expected to mitigate, if not eliminate, many of the health effects of smoking. In practice, such cigarettes are less of a health boon than they might seem. The evidence is that people smoke more of them, and smoke them more intensively, so as to sustain their nicotine intake (U.S. DHHS 1981, sec. 7; Russell 1974, p. 255). Other forms of technological breakthrough toward a "safer cigarette" may prove similarly unsuccessful, for one reason or another.[4]

In the rest of this book, I shall often refer—as a kind of shorthand—to "cigarette smoking" and "cancer" when discussing

2. These mortality ratios have remained broadly stable across time (Doll and Peto 1981, p. 1221; U.S. DHHS 1989, chap. 3). There is only a very short list of ways in which smoking contributes to longer life, as indicated by mortality ratios less than 1.0. Among them are cancer of the rectum, colorectal cancer (in women, but not in men), primary central nervous system neoplasms, and Parkinson's disease. Of these, only the latter mortality ratio can credibly be claimed to be very substantially below 1.0. See Eysenck (1986, pp. 20–21).

3. The consolidation volumes—U.S. DHEW 1976; U.S. DHHS 1989—usefully summarize findings to date. On policy responses, see esp. U.S. DHHS 1989 chaps. 7, 8.

4. In the course of recent litigation, it emerged that Liggett and Meyers had in the 1970s developed and patented a cigarette which mixed a palladium catalyst and a nitrogen salt with the tobacco, resulting in an "almost total elimination" of tumors in

these issues. But be warned, that is no more than shorthand. All modes of consuming tobacco cause significant—if not quite so dramatic—increases in the risks of contracting cancer somewhere or other in the body (U.S. DHEW 1976, chap. 10). And cancer, clearly, is not the only thing that smokers have to fear.

The evidence underlying these medical conclusions is largely epidemiological in character. They rest on analysis of statistical aggregates rather than on analysis of the aetiology of particular cases. What these studies show is simply that, in the population as a whole, smokers contract those various diseases many times more often than nonsmokers; and heavy smokers contract them much more often than light smokers. These differential rates of illness are much too large to be put down to mere chance. They seem to vary, in lagged fashion, with changes in the aggregate consumption of tobacco over time. And so on.

Strictly speaking, all that that proves is that smoking correlates with those diseases. As any first course in statistics teaches, correlation is not causation. The 1964 surgeon general's report addresses this question of causation at length, arguing, inter alia, that just as cause precedes consequence, smoking precedes cancer; just as causes are spatially contiguous to consequences, smoke touches the lung where cancer later develops; there is properly controlled experimental evidence that tars from cigarette smoke cause cancer when painted on the skin of mice and other animals; and the increases over the past century in smoking seem to correspond, in lagged fashion, so closely to increases over the same period in lung cancers that it is simply not credible that that increase in cancer could have been caused by any other factor so far suggested (U.S. DHEW 1964, pp. 19–21, 175–96; Bradford Hill 1965).

None of that yet proves causation, in an ironclad fashion. And the last point, in particular, is still sometimes challenged (Brownlee 1965; Burch 1978; Eysenck 1986, pp. 32–43). Still, the essence of scientific explanation lies in telling "plausible stories." All of that goes a substantial way toward underwriting the plausibility of the tale.

Statistical purists and tobacco apologists will nonetheless insist that the case is still "not proven" because the findings are "merely statistical" (R. J. Reynolds 1986; Burch 1978: Eysenck 1980, 1986). It

replications of the mice-painting experiments that had helped establish cigarette tars and nicotine as carcinogenic in the first place. See the *Tobacco Products Litigation Reporter* 3, no. 1 (January 1987): 8.1–8.13. The researcher responsible for this development, Dr. James Mold, disappointed that the product was never marketed, suspects the intervention of company lawyers. The company says the cigarette was never marketed because of problems with taste (Matthews 1988) similar to those forcing the withdrawal of other "nicotine-free" and "smokeless" cigarettes from the market (Freedman 1989; Morris and Waldman 1989). Experience with low tar and nicotine cigarettes suggests that, even if people were prepared to smoke the new cigarettes, they might do so in a way that mitigated the hoped-for health effects, though.



pays to consider carefully what other causal paths are being contemplated when they say that. In an early letter to the *British Medical Journal*, the distinguished statistician and geneticist, Sir Ronald Fisher (1957), identified two alternative possibilities. One is that we have the causal arrow backward and that incipient cancer is what causes people to smoke rather than vice versa. So far as I can tell, nobody has taken this possibility sufficiently seriously to investigate it properly.

The other, more worrying possibility is multicolinearity. That is simply to say that there might be some common cause that leads both to smoking and to cancer, thus rendering any apparent connection between the two wholly spurious. The textbook example of multicolinearity is that the price of rum in Havana correlates tightly with the wages of Boston preachers—not because the holy men drink up all their extra wages, thus driving up the price of rum, but, rather, because changes in the state of the world economy drive up both prices and wages (Tufte 1974, p. 19). Something similar may be going on in the link between smoking and cancer, Fisher fears.

There are, of course, a great many confounding factors involved in the relationship between smoking and lung cancer. Most of them (such as social class and workplace exposure to carcinogens) can be controlled statistically; and when they are, the relationship between smoking and cancer still remains significant. The most worrying possibilities are ones that are hard to control statistically. Primary among them is the possibility that an individual's genetic constitution causes both his smoking and his cancer, either directly (Fisher 1957; 1958; 1959; 1974, 5: 377–80, 385–432) or indirectly, through its influence on personality (Eysenck 1980).

The best test of this "genetic constitutional hypothesis" would come through a comparison of smoking and lung cancer rates among monozygotic and dizygotic twins. The former share the same genetic constitution; the latter do not, but they do presumably share much the same environment as their fraternal twins. Early studies suggested that the former were indeed significantly more alike—both in their smoking behavior and in their cancer history—than the latter. That finding lent credence to the hypothesis that there is no direct link between people's smoking and their lung cancer but, rather, that there is some third factor (their genes) that causes both. Those early studies were beset by a number of methodological problems, however (U.S. DHEW 1964, p. 190; Slade et al. 1986–87). The findings of the latest and most thorough analysis of the most comprehensive collection of twin data—the Swedish Twin Register—"speak strongly against this [genetic] constitutional hypothesis" (Cederlog, Friburg, and Lundman 1977, p. 115).[5]

5. Eysenck (1980, p. 157) dismisses those findings as "too slight to be convincing either way" but is forced to concede that the conclusions from his own twin studies are still merely "speculative," too (1986, p. 49).

Furthermore, that hypothesis is simply implausible, given what we know about the mechanisms governing the genetic transmission of personality characteristics and of susceptibility to cancer. Where two characteristics are coded on the same gene—as are, for example, skin color and susceptibility to sickle-cell anemia—there is a plausible genetic story to be told about how they can have a common genetic cause. But the relationship between smoking and lung cancer is not like that. Both human personality traits (like the propensity to smoke) and the propensity to develop most forms of human cancer seem to be the product not of a single gene—much less the same gene—but rather of interactions among multiple genes. As the surgeon general says, "the linkage (in a genetic sense) between multiple genes related to a habit (smoking) and a disease (lung cancer) in a heterogeneous population" is utterly implausible. It "would require numerous coincidences with small probabilities" all to occur simultaneously (U.S. DHEW 1964, p. 191).

Some researchers remain unpersuaded by those arguments (Eysenck 1986, pp. 52–53). And even if successful, all those arguments will have succeeded in doing is knocking out yet another alternative interpretation of the apparent link between smoking and cancer. But while the causal case is not quite proven, the hypothesis that smoking causes cancer will have been rendered substantially more credible than the most threatening alternative explanation of the apparent link.

Certainly carcinogens merely "trigger" tumors in those who are genetically predisposed, so not everyone is necessarily at equal risk from smoking. There may even be both "genetic constitutional" and genuinely "causal" factors linking smoking and cancer (Burch 1978). Advocates of curbs on smoking can concede all that without cost. Their case goes through perfectly well, just so long as: a sufficiently large proportion of the population is genetically vulnerable; among them, smoking makes a sufficiently large contribution in causing their cancers; and there is no way, technically or politically, to target truly effective antismoking policies only at those who are genetically at risk. Given the likelihood of each (indeed, of all) of these conditions being satisfied, antismoking policies can nonetheless be defended as important contributions to public health.[6]

Were we to regard the case against a suspected carcinogen as "not proven" for purposes of public policy-making until we identified the precise mechanism by which it caused cancer, we would have to wait until we found the cause of cancer itself before we could regulate carcinogens at all, however strong the statistical evidence linking the

6. Strides are being made in identification of those at especially high risk of lung cancer and cardiac disease in consequence of smoking (Russell 1974, p. 257); but that, in itself, is not enough to undercut this case for a general antismoking campaign.



substances in question to cancer might be. By that standard, wildly carcinogenic substances like plutonium could be sold over the counter. By similar standards, thalidomide could still be marketed: we know it causes birth defects, but not exactly how or why. Or, again, by similar standards we might be obliged to ban apparently safe and effective drugs from the market until we knew precisely how they worked to effect their cures. In all those cases, such a standard of proof would be unreasonably high to require (Bradford Hill 1965; Armitage 1978, p. 460; Galbraith 1959).

In addition to questions about the standard of proof to be required, there are also questions to be raised about the allocation of the burden of proof itself. If we see ourselves as interfering with the liberty of manufacturers, we might more naturally suppose the burden of proof should lie with them to prove their product safe. If we see ourselves as interfering with the liberty of consumers, it would be a case of paternalism, and we would be more inclined to suppose that the burden lies with the government to prove products unsafe before prohibiting people from using them (Dworkin 1972/1983, pp. 33–34). Any manufactured good, cigarettes included, could equally legitimately be viewed under either description, of course; so, useful though that general principle might be in explicating the phenomenology of the situation, it is useless in providing any real policy guidance.

Those who argue against policies to curb smoking on the grounds that the case against it is still "not proven" are implicitly asking us to presume a product safe until proven otherwise. In practice, U.S. regulatory policy characteristically employs almost exactly the opposite presumption. Under the Food, Drug and Cosmetic Act, as amended in 1958, it is the manufacturer of a new drug or food additive that must bear the burden of demonstrating that the product is safe and effective, which in practice means "producing at least four and possibly more than ten valid studies involving rodent and nonrodent toxicity, cancer, and other tests. Moreover, no additive can be approved as safe 'if it is found . . . to induce cancer in man or animal' " in any measure at all (Breyer 1982, p. 134).

Now, as it happens, cigarettes stand outside the statutory boundaries governing this regulatory regime. Being classified for these purposes as neither a food nor a drug, cigarettes are beyond the Food and Drug Administration (FDA)'s jurisdiction.[7] Furthermore, under

7. Why that should be so is in and of itself an interesting story. "The item 'Tobacco' appeared in the 1890 edition of the *U.S. Pharmacopoeia*, an official listing of drugs published by the government. It did not appear in the 1905 or later editions . . . because the removal of tobacco from the *Pharmacopoeia* was the price that had to be paid to get the support of tobacco state legislators for the Food and Drug Act of 1906. The elimination of the word tobacco automatically removed the leaf from FDA supervision" (Fritschler 1969, p. 37).

that legislation, the FDA's prior approval is not required for marketing various categories of items: "natural constituents of food"; substances "generally recognized among experts as safe"; and products on the market before the 1958 enactment.[8] So even if cigarettes were brought under the ambit of FDA regulations, the carcinogens they contain might still be able to claim exemption from the regulations under the first and third of those other clauses.

All that speaks solely to the question of what the law, as it stands, happens to be. What the law ought morally to require is, perhaps, something else. In those terms, there seems to be a strong case for treating all carcinogenic consumer products the same. The most we might reasonably want to do is to presume products safe until the first sign that they might cause cancer emerges. But at the first sign that they might cause cancer, the presumption should shift; at that point, the burden of proof should fall upon those who would market potentially cancer-causing agents to prove that their products are safe. That is the way the FDA behaves in assessing most drugs and food additives. That is the way that the public at large reacts to evidence that cigarette smoking causes cancer, as tobacco companies themselves are the first to appreciate.[9]

For those things which we are 95 percent certain cause cancer or 95 percent certain do not, it makes no difference to our final decision which way we set the presumption. For those cases in which neither is true, however, the presumption will alone dictate the decision. There, it is absolutely crucial which way that presumption is set.

Alternatively, we might not want to operate with any presumption or burden of proof at all in these areas. The alternative would be to judge substances carcinogenic if, on the balance of available evidence, they seem more likely than not to cause cancer. Such a rule would avoid excesses in both directions. It would avoid banning substances at the first sign that they might cause cancer, as now

8. Note, however, that "the FDA can proceed against" the latter products "by showing in court that they are 'injurious to health' " (Breyer 1982, p. 134). Thus, such products are not necessarily exempted from regulation altogether—the burden of proof has merely shifted to the government.

9. In a confidential briefing to the Philip Morris board of directors in October 1964, its operations department stated that, thanks to the surgeon general's report, "in the public eye the burden of proof had been shifted from the accusers of cigarettes as a health hazard to the cigarette producers. It was now up to the cigarette companies to prove that cigarettes are safe or that safe ones could be made. In this connection it is our opinion that the industry must somehow find a way to make an effective *technical rebuttal* to the arguments of the anti-cigarette forces. Only in this way will the present burden be lifted from us." This document was released in connection with litigation of Cipollone v. Liggett Group (U.S. District Court for the District of New Jersey, Civil Action no. 83–2864) as Plaintiff's Exhibit no. 613; the quotation is from p. 3 of that document.



happens under the Delaney Amendment governing the FDA; but it would not go so far as to allow substances to continue being marketed as presumptively safe on equally slight evidence (Page 1978; see, further, Morrison and Henkel 1970; Atkins and Jarrett 1979).

Either way, however, tobacco surely has to be treated as if it caused cancer. It stands indicted, whether by presumption or by the balance of evidence. Indeed, on the above evidence, it would stand indicted at the .05 confidence level even if the presumption were set in favor of its safety: question as they might whether correlation proves causation, even friends of tobacco concede that, statistically (for what that is worth), there is much less than a 5 percent chance that the observed relationship between smoking and cancer would have occurred randomly.

## 2.2 DO SMOKERS VOLUNTARILY ACCEPT THE RISKS?

Given what we know of the health risks from smoking, we may well be tempted to "ban cigarette manufacturers from continuing to manufacture their product on the grounds that we are preventing them from causing illness to others in the same way that we prevent other manufacturers from releasing pollutants into the atmosphere, thereby causing danger to members of the community." That would be to move too quickly, though. For as Dworkin (1972/1983, p. 22) goes on to say, "The difference is . . . that in the former but not the latter case the harm is of such a nature that it could be avoided by those individuals affected, if they so chose. The incurring of the harm requires the active cooperation of the victim. It would be a mistake in theory and hypocritical in practice to assert that our interference in such cases is just like our interference in standard cases of protecting others from harm."

The courts have been as sensitive to this distinction as have moral philosophers. They appeal to the venerable legal maxim, *volenti non fit injuria*, to hold that through their voluntary assumption of the risk smokers have waived any claims against cigarette manufacturers. In perhaps one of the most dramatic cases in this area (given the well-established synergism between smoking and asbestos inhalation in causing lung disease), the Fifth Circuit refused to enjoin cigarette manufacturers as codefendants in a suit against Johns-Manville, saying that "the danger is to the smoker who willingly courts it."[10]

Certainly there is, morally speaking, a world of difference between the harms that others inflict upon you and the harms that

10. Johns-Manville Sales Corp. v. International Association of Machinists, Machinists Local 1609, 621 F.2d 756, 759 (5th Cir. 1980). See, further, Daniels 1985, p. 155, n. 8; cf. Anonymous 1986.

you inflict upon yourself. The question is simply whether, in the case of smoking, the active cooperation of the smoker really is such as to constitute voluntary acceptance of the consequent risks of illness and death. The question is decomposable into two further ones. The first, discussed in section 2.2.1, concerns the question of whether smokers know the risks. The second, discussed in section 2.2.2, concerns the question of whether, even if smoking in full knowledge of the risks, they could be said to "accept" the risks in a sense that is fully voluntary.

### 2.2.1 *Do Smokers Know the Risks?*

Here we are involved, essentially, with a question of "informed consent." People can be held to have consented only if they knew to what they were supposedly consenting. In the personalized context of medical encounters, this means that each and every person being treated is told, in terms he understands, by the attending physician what the risks of the treatment might be (Gorovitz 1982, chap. 3). For largely anonymous transactions in the market, such personalized standards are inappropriate. Instead, we are forced to infer consent from what people know or should have known (in the standard legal construct, what a "reasonable man" should have been expected to know) about the product. And in the anonymous world of the market, printed warnings necessarily take the place of face-to-face admonitions.

Cigarette manufacturers, in defending against product liability suits, have claimed on both these grounds that smokers should be construed as having consented to whatever risks that they have run (Edell and Gisser 1985; American Medical Association [AMA] 1986; Anonymous 1986). They claim, first, that any "reasonable" person should have known—and that the "ordinary consumer" did indeed know—that smoking was an "inherently dangerous" activity.[11] Their interrogatories (pretrial questions put to the plaintiff before a case comes to trial) constantly seek to establish that plaintiffs had in their youth consorted with people calling cigarettes "coffin nails," and so on.[12]

11. Recent tort law revisions in California and New Jersey bar product-liability actions altogether against manufacturers of "products that are inherently dangerous and are known to be unsafe by the ordinary consumer" (Cohen 1987, p. 8; see, further, Daynard 1988, p. 12). In order to avail themselves of this protection, however, manufacturers will have to prove that their products are inherently dangerous. That would compromise their defenses against liability claims in other jurisdictions and would undermine their public standing more generally, so on balance they may well prefer to shun this option.

12. See, e.g., those reprinted in the *Tobacco Products Litigation Reporter* 2, no. 7 (July/August 1987): 3.365–400, 3.441–60.



Of course, claiming that any reasonable person should have known smoking was unhealthy sits uneasily with the same corporations' claims—often in the very same litigation—that there is no evidence that smoking causes cancer, either in general or in the plaintiffs' particular cases (Anonymous 1986, p. 817). Caught in this inconsistency, one tobacco company recently withdrew any claims as to the plaintiff's negligence, lest it be required to answer interrogatories stating exactly what any "reasonable person" should have known about the dangers of its products (Mintz 1987).

Cigarette manufacturers have a fallback position here, though. They claim, second, that the printing of government-mandated health warnings on cigarette packets from 1966 onward has constituted further, explicit warning to users of the dangers of the products. The question, recall, is whether consumers were warned of the risks, not who warned them or why. So the fact that the health warnings were required by the Congress rather than printed voluntarily by manufacturers does nothing to undercut their value for this purpose. Indeed, according to the current run of court opinions, that might actually enhance the value of such warnings in deflecting tort liability suits.[13]

Not only are those government health warnings printed on cigarette packets useful in defending companies against claims for harms that were inflicted at some time after 1966, when they first appeared, but tobacco company lawyers defending against product liability suits have even tried to use post-1966 behavior to infer "hypothetical consent" to risks before the warnings were given. As one company attorney argued in *Cipollone v. Liggett Group*, "because Rose Cipollone continued to smoke for at least 15 years while warnings were on every pack she bought, she would have smoked before January 1, 1966, even if the defendants had voluntarily warned her about possible health consequences" (quoted in Mintz 1988a). Now, there may be certain circumstances in which hypothetical consent can be a convincing argument—some such logic must be what justifies the physician in cutting open the comatose patient in the emergency room, for example. This case does not seem to be among them, though. What we have here is more like an amateur boxer mugging you, on the grounds that since you belong to the same boxing club you obviously would have agreed to fight him if he had only asked. It takes actual, not merely hypothetical, consent to defend against a charge of assault and battery. Likewise, I would argue, in the case of the tobacco companies. That the companies

13. Reference here is to the "preemption" defense, discussed more fully on pages 49–50 below.

should try to run the argument at all is indicative, however, of the hopes that they are pinning on printed warnings to relieve them of legal liability.

In the best of circumstances, warnings—whether from government or grandmother—will only get us so far. There are some risks of which smokers have historically never been warned by either government or grandmother. Among them are things like Buerger's disease, a circulatory condition induced in often quite young people by smoking, that can result in amputation of limbs.[14]

Furthermore, the warnings of both folk wisdom and cigarette packets, in the 1960s and 1970s at least, were desperately nonspecific. A more general question therefore arises: are all-purpose warnings that "*X* is hazardous to your health," without specifying just how likely *X* is to cause just what sorts of harms, adequate warning to secure people's informed consent, at all? Certainly the psychological evidence suggests that an explicit, concrete message is a better spur to action than a vague, abstract one (Borgida and Nisbett 1977).

Problems of nonspecific warnings are not peculiar to cigarettes, of course. In principle, they might be as much of a problem with lawn mowers and insecticides. In practice, though, warnings there tend to be stated more strongly: they tend to say that certain bad things *will* happen to you if the product is misused (e.g., you will be poisoned), not just that they *may* (i.e., not just that the product "is dangerous to your health"); they mention death explicitly (often employing the conventional skull-and-crossbones symbol on the label); they suggest specific antidotes; and so on. All those factors make those warnings more successful at what warnings are supposed to do—convey a real sense of the seriousness of the hazard—than do the sorts of milquetoast warnings traditionally carried on cigarette packets.

There is a fair bit of evidence that smokers—especially young smokers—simply do not read what appears inside the surgeon general's boxed warning on cigarette packets and advertisements. One study, for example, monitored eye tracking of adolescents viewing tobacco advertisements and found that almost half of them did not cast eyes on the warning at all; when subsequently asked to identify, from the surgeon general's rotating list of warnings, which it was that appeared in the advertisement they had seen, subjects did only slightly better than random (Fischer et al. 1989). Warnings that are not—and perhaps are designed not to be—read cannot possibly be

14. Neither do cigarette packets warn, as some drug containers do, that the product is addictive (Garner 1980; Schwartz 1989). But if tobacco is truly addictive, then it is that addictiveness rather than the failure to warn of addictiveness that blocks consent-based defenses, as argued in sec. 2.2.2 below (cf. Wikler 1978/1983, p. 39).



effective. The evidence suggests that tobacco health warnings fall largely into that category.

As important, cigarette manufacturers take back through their advertising what is given, inside the surgeon general's boxed notice, by way of warnings (White 1988, chap. 6). There are various examples. Admonitions that "smoking is dangerous to your health," when conjoined with pictures of people enjoying dangerous sports (white water rafting, and the like), perversely serve to make smoking more attractive. Warnings that "smoking by pregnant women may result in fetal injury, premature birth, and low birth weight," when conjoined with sexually provocative photos in magazines devoted to casual sex without procreation, again perversely undercut the health message. Perhaps most important of all, advertising that appeals to the rebelliousness of youth in general and young women and young blacks in particular (the "You've come a long way, baby" campaign, e.g.) constitutes a thinly veiled invitation for them to ignore the advice of authorities. Particularly striking, in this connection, was a 1983 billboard campaign in Britain employing the caption, "We're not allowed to tell you anything about Winston cigarettes, so here's a man blowing a raspberry" (Chapman 1986, p. 16).[15]

The problem is not so much one of literally deceptive advertising, though there is evidence of some of that (U.S. Federal Trade Commission [FTC] 1981, 1984, 1985), particularly in earlier periods (Rothenberg 1988).

> Since the early 1930s, the [Federal Trade] Commission . . . brought approximately 20 actions against cigarette companies for false or misleading advertising. Many of those actions involved what the Commission considered misleading health claims. The manufacturers of Chesterfields were prohibited, for example, from claiming their product had "no adverse effect upon the nose, throat or accessory organs." Another producer was proscribed from claiming that Kools will keep one's head clear in winter . . ., give extra protection, or provide an excellent safeguard during cold months. [Fritschler 1969, pp. 29–30]

Despairing of a case-by-case strategy for controlling such deceptive advertising, the Federal Trade Commission felt compelled, in September 1955, to lay down certain mandatory "guides" for cigarette

15. Some would argue that smokers were better informed in the past, when unregulated advertisers employed "knocking copy" to point out health risks of other brands of cigarettes (Calfee 1986). Those arguments are highly suspect, though. The central claim of such advertisements, after all, was that the advertiser's own brand was free from the defects found in others.

advertising including, inter alia: "a ban on assertions that smoking had favorable effects on the respiratory, digestive, or nervous system; a ban on claims of medical approval of smoking, or of a particular brand; and a ban on any unproven claim of nicotine content" (White 1988, p. 39; see also Fritschler 1969, p. 30). Ultimately the Federal Trade Commission itself agreed even that was inadequate to curb deceptive trade practices in the tobacco industry (Fritschler 1969, pp. 70–72).

The greater contemporary problem, though, lies not in any literally false claims cigarette advertisements make for their products. It lies instead in the widespread use, in them, of deceptively healthy imagery (U.S. FTC 1981, pp. 428a, 491a). The printed warnings may say "smoking kills." But the advertising images are the very picture of robust good health. Cowboys, sports, and the great outdoors figure centrally in the ads. The U.S. Federal Trade Commission has continually warned Congress that "current practices and methods of cigarette advertising" have the effect of "reducing anxieties about the health risks posed by cigarette smoking" (U.S. FTC 1984, p. 5), "negat[ing] the effect of health warnings because they imply that smoking is a habit which is compatible with performing various outdoor activities and having a strong healthy body" (U.S. FTC 1985, p. 5).[16]

The point being made here is not that advertising bypasses consumers' capacity to reason, and somehow renders them unfree to choose intelligently whether or not to partake of the product. No one is saying that consumers of tobacco are brainwashed to quite that extent. The central point here is merely that the tobacco companies in effect are giving out—and, more important, consumers are receiving—conflicting information. The implicit health claims of the advertising imagery conflict with the explicit health warnings, and thus undercut any *volenti* or informed consent defense companies might try to mount on the basis of those warnings (Edell and Gisser 1985).

### 2.2.2 *Is Acceptance of the Risks Fully Voluntary?*

Obviously, people cannot voluntarily accept the health risks of smoking if they do not know what they are. Despite tobacco companies' best

16. Literally, of course, it is—at least broadly speaking and in the short run. But in the medium to long term, participation even in purely recreational sport (not to mention serious sport, where peak performance is required) is impaired by the consequences of smoking. Insofar as young smokers are encouraged in the belief that they can always quit, should smoking become a problem later, that is a false belief (as shown by the addiction evidence, discussed below); and advertisements carrying any such implications once again would count as clearly deceptive advertising.



efforts, though, the great majority of people—smokers included—knows, in broad outline, what health risks smoking entails. In a 1978 Gallup poll, only 24 percent of even heavy smokers claimed that they were unaware of, or did not believe, the evidence that smoking is hazardous to health (Anonymous 1986, p. 814, n. 26; U.S. FTC 1981, p. 433a). That figure might somewhat overstate the extent of their acceptance of the statistics. There are various other false beliefs smokers sometimes employ to qualify their acceptance of those statistics and hence to rationalize their continued smoking (e.g., that the lethal dose is far in excess of what they smoke, however many that may be) (Marsh 1985, p. 8). Still, we can reasonably suppose that, in some sense or another, well over half of smokers know that what they are doing is unhealthy.

It is worth pausing, at this point, to consider just how we should handle that recalcitrant residual of smokers who deny the evidence. Having smoked thousands of packets containing increasingly stern warnings, and having been exposed to hundreds of column inches of newspaper reporting and several hours of broadcasting about smoking's hazards, they are presumably incorrigible in their false beliefs in this regard. Providing them with still more information is likely to prove pointless (cf. Feinberg 1971/1983, p. 11). People will say "if they are so bad for you as all that the government would ban cigarettes altogether." Or they will say "the government says that nearly everything is bad for you." Or they will find still some other way of rationalizing the practice.

Ordinarily it is not the business of public policy to prevent people from relying on false inferences from full information which would harm only themselves. Sometimes, however, it is. One such case comes when the false beliefs would lead to decisions that are "far-reaching, potentially dangerous, and irreversible"—as, for example, with people who believe that when they jump out of a tenth-story window they will float upward (Dworkin 1972/1983, p. 31; see also Feinberg 1971/1983, p. 7).

We are particularly inclined toward intervention when false beliefs with such disastrous results are traceable to familiar, well-understood forms of cognitive defect (Sunstein 1986, pp. 1161–64). There is something deeply offensive—morally, and perhaps legally as well—about the "intentional exploitation of a man's known weaknesses" in these ways (White 1972).

One such familiar form of cognitive defect is "wishful thinking": smokers believing the practice is safe because they smoke, rather than smoking because they believe it to be safe (Pears 1984). There is substantial evidence that smokers believe, groundlessly, that they are less vulnerable to smoking-related diseases (Leventhal, Glynn, and

Fleming 1987, p. 3374). More surprising, and more directly to the "wishful thinking" point, is the evidence that smokers came to acquire those beliefs in their own invulnerability, and to "forget" what they previously knew about the dangers of smoking, *after* they took up the habit.[17]

Another cognitive defect is the so-called anchoring fallacy (Kahneman, Slovic, and Tversky 1982). People smoke many times without any (immediately perceptible) bad effects. Naturally, people extrapolate from their own experience. They therefore conclude—quite reasonably, but quite wrongly—that smoking is safe, at least for them.

Yet another phenomenon, sometimes regarded as a cognitive defect, is "time discounting." Sometimes the ill effects of smoking would be felt almost immediately. Tonight's cigarette will make me short of breath when jogging tomorrow morning, for example. To ignore such effects, just on the grounds that they are in the future, is obviously absurd when the "future" in question is so close; it would imply a discount rate of 100 percent per hour, "compounding to an annual rate too large for my calculator," as Schelling (1980, p. 99) sneers. But most of the really serious consequences of smoking are some decades away for most of us. And since young smokers will not suffer the full effects of smoking-related diseases for some years to come, they may puff away happily now with little regard for the consequences, just so long as they attach relatively little importance to future pains relative to present pleasures in their utility functions (Fuchs 1982). Economists, of course, are inclined to regard a "pure time preference" as a preference like any other, neither rational nor irrational. But reasons can be given for thinking that a lack of due regard for one's own future truly is a form of cognitive defect.[18]

17. In the crucial study Alexander, Calcott, and Dobson (1983) administered a twenty-eight-item questionnaire about the health risks of smoking to 6,000 school children aged ten to twelve. Then they exposed them to a health education program informing them, among other things, about the health consequences of smoking. When administering the same twenty-eight-item questionnaire to the same children a year later, the researchers came upon this startling discovery: those children who had taken up smoking over the course of the year showed a decrease in knowledge on that test compared to their previous year's score, whereas other children who had not begun to smoke showed significant increases.

18. Daniels (1985, p. 99) tries to show its irrationality by inviting us to construct a notion of a "hypothetical agent, . . . abstract[ing] from certain features of individuals" as we know them. He then argues that it would be prudent for (i.e., rationally incumbent upon) such agents to take a strong interest in their futures. That amounts to a quasi-Rawlsian appeal against the *injustice* of time-discounting, though. It does not, strictly speaking, demonstrate its imprudence or irrationality. My preferred argument is this: suppose, plausibly enough, that your later self will prefer that your earlier self had taken its later interests more seriously. Then want-regarding moralities (utilitarianism, certainly) would put this later claim fully on a par with that of the earlier self (Goodin 1982, chap. 3). So long as earlier and later selves are instantiations of one and the same person, we can say that the earlier one is therefore "irrational" not to take properly into account his later interests. (If they are not the "same person," it is indeed appropriate to appeal to norms of justice: it is unjust for one person to take advantage of another in this way, whether or not they share the same body at different moments.)



All of these cognitive defects point to relatively weak forms of irrationality, to be sure.[19] In and of themselves, they might not be enough to justify interference with people's liberty, perhaps. When they lead people to take decisions that are far-reaching, potentially life-threatening, and irreversible, though, perhaps intervention would indeed be justifiable.

Interfering with people's choices in such cases is paternalistic, admittedly. But there are many different layers of paternalism (Sartorius 1983; Feinberg 1986). What is involved here is a relatively weak form of paternalism, one that works within the individual's own theory of the good and merely imposes upon him a better means of achieving what after all are only his own ends.[20] It is one thing to stop people who want to commit suicide from doing so, but quite another to stop people who want to live from acting in a way that they falsely believe to be safe (Feinberg 1971/1983, p. 10; Dworkin 1972/1983, pp. 23, 33). Smokers who deny the health risks fall into that latter, easier category.

The larger and harder question is how to deal with the great majority of smokers who, knowing the risks, continue smoking anyway. Of course, it might be said that they do not *really* know the risks. Although most acknowledge that smoking is "unhealthy," in some vague sense, few know exactly what chances they run of exactly what diseases. In one poll, 49 percent of smokers did not know that smoking causes most cases of lung cancer, 63 percent that it causes most cases of bronchitis, and 85 percent that it causes most cases of emphysema (U.S. FTC 1981, pp. 345a–364a; see similarly Marsh 1985).

Overestimating badly the risks of dying in other more dramatic ways (such as car crashes, etc.), people badly underestimate the

19. The addiction evidence surveyed in sec. 2.2.2 below *is* evidence of genuine, full-blown irrationality; and it might explain why people are so prone to these more modest cognitive errors, when it comes to smoking, as well.

20. One of a person's ends—continued life—at least. Perhaps the person has other ends ("relaxation," or whatever) that are well served by smoking; and insofar as "people taking risks actually value the direct consequences associated with them . . . it is more difficult to intrude paternalistically" (Daniels 1985, pp. 158, 163). But assuming that smoking is not the only means to the other ends—not the only way to relax, etc.—the intrusion is only minimally difficult to justify.

relative risks of dying in the more mundane ways associated with smoking. This allows them to rationalize further their smoking behavior as being "not all that dangerous," compared to other things that they are also doing.

Of course, logically it would be perfectly possible for people both to underestimate the extent of a risk and simultaneously to overreact to it. People might suppose the chances of snakebite are slight but live in mortal fear of it nonetheless. Psychologically, however, the reverse seems to happen. People's subjective probability estimates of an event's likelihood increase the more they dread it, and the more "psychologically available" the event therefore is to them (Kahneman, Slovic, and Tversky 1982). Smoking-related diseases, in contrast, tend to be "quiet killers" of which people have little direct or indirect experience, which tend to be underreported in newspapers (typically not even being mentioned in obituary notices) and which act on people one at a time rather than catastrophically killing many people at once (Lichtenstein et al. 1978, p. 567). Smoking-related diseases being psychologically less available to people in these ways, they underestimate their frequency dramatically—by a factor of 8, in the case of lung cancer, according to one study (Slovic, Fischhoff, and Lichtenstein 1982, p. 469).[21]

Besides all that, there is the distinction between "knowing intellectually" some statistic and "feeling in your guts" its full implications. Consent counts—morally, as well as merely legally—only if it is truly informed consent, that is to say, only if people really know what it is to which they are consenting. That, in turn, requires not only that we can state the probabilities but also that we "appreciate them in an emotionally genuine manner" (Dworkin 1972/1983, p. 30). There is reason to believe that smokers do not (U.S. FTC 1981, p. 428a).

It may still be argued that, as long as people had the facts, they can and should be held responsible if they chose not to act upon them when they could have done so. It may be folly for utilitarian policymakers to rely upon people's such imperfect responses to facts for purposes of constructing social welfare functions and framing public policies around them. But there is the separate matter of who ought to be blamed when some self-inflicted harm befalls people. There, arguably, responsibility ought to be on people's own shoulders (Knowles 1977; Wikler 1987). Arguably, we ought to stick to that judgment, even if people were "pressured" into smoking by the

21. Thus, health education campaigns have begun focusing on the risks of contracting Buerger's disease from smoking, the amputation of limbs being, like snakebites, psychologically more accessible to people (especially teenagers, before they start to smoke) than rotting lungs.



bullying of aggressive advertising or peer group pressure (cf. Gewirth 1980, pp. 124–25; Daniels 1985, p. 159).

What crucially transforms the "voluntary acceptance" argument is evidence of the addictive nature of cigarette smoking. Of course, saying that smoking is addictive is not to say that all smokers are hooked and none can ever give it up. Clearly, many have done so. By the same token, though, "most narcotics users . . . never progress beyond occasional use, and of those who do, approximately 30 percent spontaneously remit" (U.S. DHHS 1988, p. v). Surprisingly enough, studies show that more than 70 percent of American servicemen addicted to heroin in Vietnam gave it up when returning to the United States (Robins 1973; Pollin 1984; Fingarette 1975, pp. 429–31). We nonetheless continue to regard heroin as an addictive drug. The test of addictiveness is not impossibility but rather difficulty of withdrawal.

There is a tendency, in discussing *volenti* or informed consent arguments, to draw too sharp a distinction between "voluntary" and "involuntary acts" and to put the dividing line at the wrong place, at that (Feinberg 1986, chap. 20). The tendency is often to assume that any act that is in the least voluntary—that is in any respect at all, to any extent at all, within the control of the agents themselves—is to be considered fully voluntary for the purposes. If we want to claim that some sort of act was involuntary, we are standardly advised to look for evidence of "somnambulism" or "automatism" or such like (Prevezer 1958; Fox 1963). Thus, U.S. Supreme Court justices wanting to argue for more humane treatment of addicts felt obliged to assert that "once [the defendant] had become an addict he was utterly powerless" to refrain from continuing to service his addiction (Fortas 1968, p. 567). That is an implausibly strong claim, given the above evidence.

There is no need to make such a strong claim, though, to vitiate arguments that the conduct was "voluntary" and the harm thus self-incurred. For purposes of excusing criminal conduct, we are prepared to count forms of "duress" that stop well short of rendering all alternative actions literally impossible. It is perfectly possible for bank tellers to let a robber break their arms instead of handing over the money; but no one expects them to do so. A credible threat of serious pain, or perhaps even very gross discomfort, is ordinarily regarded as more than sufficient to constitute duress of the sort that excuses responsibility for otherwise impermissible behavior.

So, too, I would argue should be the case with addiction-induced behavior. The issue is not whether it is literally impossible, but merely whether it is unreasonably costly, for addicts to resist their compulsive desires. If that desire is so strong that even someone with " 'normal and reasonable' self-control" (Watson 1977, p. 331) would succumb to

it, we have little compunction in saying that the addict's free will was sufficiently impaired that his apparent consent counts for naught.[22]

This is arguably the case with nicotine addiction. To establish a substance as addictive, we require two sorts of evidence. The first is some sort of evidence of "physical need" for the substance among its users. That evidence is widely thought necessary to prove smoking is an addiction, rather than just a "habit" (U.S. DHEW 1964, chaps. 13–14), a psychological dependence, or a matter of mere sociological pressure (Daniels 1985, p. 159)—none of which would undercut, in a way that addictiveness does, claims that the risks of smoking are voluntarily incurred. That physical link has now been established, though. Particular receptors for the active ingredients of tobacco smoke have been discovered in the brain; the physiological sites and mechanisms by which nicotine acts on the brain have now been well mapped, and its tendency to generate compulsive, repetitive behavior in consequence has been well established. Such evidence—summarized in the surgeon general's 1988 report (U.S. DHHS 1988, chaps. 3–4; see also Leventhal and Cleary 1980; and Winsten 1986)—has been one important factor in leading the World Health Organization ([WHO] 1978) and the American Psychiatric Association ([APA] 1987, sec. 305.1) to classify nicotine as a dependence-inducing drug. (Strictly speaking, the term "addiction" is out of favor in these circles, with "dependence" taking its place; in what follows, I shall continue using the more colloquial term in preference to the more technical one, though.)

None of that evidence proves that it would be literally impossible for smokers to resist the impulse to smoke. Through extraordinary acts of will, they might. Nor does any of that evidence prove that it is literally impossible for them to break their dependence altogether. Many have. Recall, however, that the issue is not one of impossibility but rather of how hard people should have to try before their will is said to be sufficiently impaired that their agreement does not count as genuine consent.

The evidence suggests that nicotine addicts have to try very hard indeed. This is the second crucial fact to establish in proving a

22. Some would question whether drug withdrawal symptoms in general are really so severe as to justify claims of involuntariness by reason of "pharmacological coercion." Fingarette (1975, p. 437; see also Fingarette 1970) may well be right that the effects of withdrawal are largely in the addict's own mind and that they loom much larger in prospect among addicts contemplating withdrawal than they turn out to have been in retrospect after withdrawal has been successfully accomplished. Still, it is the agent's beliefs that are always the keys to coercion: if the bank tellers believed the robber's gun was loaded, they handed over the money under duress and are excused for that reason, even if it turns out that the gun's chambers were empty.



substance addictive.[23] Central among the WHO/APA criteria for diagnosing nicotine dependence is the requirement of evidence of "continuous use of tobacco for at least one month with . . . unsuccessful attempts to stop or significantly reduce the amount of tobacco use on a permanent basis" (APA 1987, sec. 305.1).

A vast majority of smokers do indeed find themselves in this position. The surgeon general reports the results of various studies showing that 90 percent of regular smokers have tried to quit (U.S. DHHS 1979, quoted in Pollin 1984). Another 1975 survey found that 84 percent of smokers had attempted to stop, but that only 36 percent of them had succeeded in maintaining their changed behavior for a whole year (Benfari, Ockene, and McIntyre 1982; see, further, Leventhal and Cleary 1980). Interestingly, graphs mapping the "relapse rate"—the percentage of ex-addicts that are back on the drug after a given period of time—are almost identical for nicotine and for heroin (Winsten 1986; U.S. DHHS 1988, p. 314 and chap. 5 more generally).[24]

On the basis of all this evidence, the surgeon general has been led to three "major conclusions" contained in his 1988 report:

1. Cigarettes and other forms of tobacco are addicting.
2. Nicotine is the drug in tobacco that causes addiction.
3. The pharmacologic and behavioral processes that determine tobacco addiction are similar to those that determine addiction to drugs such as heroin and cocaine. [U.S. DHHS 1988, p. 9]

Evidence of smokers trying to stop and failing to do so is rightly regarded as central to the issue of addiction, philosophically as well as diagnostically. Some describe free will in terms of "second-order volitions"—desires about desires—controlling "first-order" ones (Frankfurt 1971). Others talk of free will in terms of a person's "evaluational structure" controlling his "motivational structure"—a

23. There are other physical needs that we would have trouble renouncing—such as our need for food—that we would be loath actually to call "addictions." Be that terminological issue as it may, we would also be loath, for precisely those reasons of physical need and the difficulty of renouncing it, to say that we eat "of our own free will." (We would have no hesitation that someone who makes a credible threat of preventing us from eating has thereby "coerced" us.) Since involuntariness and impairment of free will are what is really at issue here, those thus do seem to be the aspects of addictiveness that ground the conclusion that we do not voluntarily consent to the risks associated with addictive substances.

24. It might be wrong to make too much of that fact, however. Perhaps heroin addicts find both (*a*) that it is harder to give up and (*b*) that they have more reason to do so. Then relapse rates would appear the same, even though heroin is more addictive, in the sense of being harder to give up.

person striving to obtain something if and only if he thinks it to be of value (Watson 1975; 1977). Addiction—the absence of free will—is thus a matter of first-order volitions winning out over second-order ones, and surface desires prevailing over the agent's own deeper values. In the case of smoking, trying to stop can be seen as a manifestation of one's second-order volitions, or one's deeper values, and failing to stop as evidence of the triumph of first-order surface desires over them. The same criteria the WHO and APA use to diagnose nicotine dependence also establish the impairment of the smoker's free will, philosophically.

For certain purposes, at least, even the courts now treat nicotine as addictive. Social security benefits are not payable to those claimants whose disabilities were voluntarily self-inflicted. But the courts have held that "smoking can be an involuntary act for some persons," and that those benefits may not therefore be routinely withheld from victims of smoking-related diseases on the grounds that they are suffering from voluntarily self-inflicted injuries.[25]

Various other policy implications also follow from evidence of addictiveness, though. One might be that over-the-counter sales of cigarettes should be banned. If the product is truly addictive, then we have no more reason to respect a person's voluntary choice (however well-informed) to abandon his future volition to an addiction than we have for respecting a person's voluntary choice (however well-informed) to sell himself into slavery (Mill 1859/1975, pp. 126–27). I am unsure how far to press this argument, since after all we do permit people to bind their future selves (through contracts, e.g.). But if it is the size of the stakes or the difficulty of breaking out of the bonds that makes the crucial difference, then acquiring a lethal and hard-to-break addiction is much more like a slavery contract than it is like an ordinary commercial commitment (cf. Feinberg 1986, pp. 71–81).

In any case, addictiveness thus defined makes it far easier to justify interventions that on the surface appear paternalistic. In some sense, they would then not be paternalistic at all. Where people "wish to stop smoking, but do not have the requisite willpower . . . we are not imposing a good on someone who rejects it. We are simply using coercion to enable people to carry out their own goals" (Dworkin 1972/1983, p. 32).[26]

25. Gordon v. Schweiker, 725 F.2d 231, 236 (4th Cir. 1984).

26. That is one way of explaining an apparent paradox surrounding "sin" taxes in general: "items such as alcohol [and cigarettes] are so commonly consumed, and so little complaint is made about large excise taxes" on them, that microeconomists are led to conclude that it simply must be in the individual's own perceived interest, somehow, to be so taxed (Crain et al. 1977).



There is, of course, a genuine difficulty in deciding which is the "authentic" self. With whom should we side, when the person who asks us to help him to "enforce rules on himself" repudiates the rules at the moment they come to need to be enforced (Schelling 1980; 1983; 1984a; 1984b; 1985).[27] But at least we have more of a warrant for interference, in such cases, than if we were never asked for assistance by the agent at all.

Much of the assistance that we have to render in such situations will necessarily be of a very personal nature, and it will be outside the scope of public policy for that reason. There is nonetheless a substantial role for public policy in these realms. Banning or restricting smoking in public places (especially the workplace) can contribute crucially to an individual's own efforts at smoking cessation, for example (Etzioni 1978, pp. 67–68; Leventhal and Cleary 1980; U.S. DHHS 1986, chap. 6).

The real force of the addiction findings, in the context of *volenti* or informed-consent arguments, though, is to undercut the claim that there is any *continuing* consent to the risks involved in smoking. There might have been consent in the very first instance—in smoking your first cigarette. But once you were hooked, you lost the capacity to consent in any meaningful sense on a continuing basis (White 1972). As Hume (1760) says, to consent implies the possibility of doing otherwise; and addiction substantially deprives you of the capacity to do other than continue smoking. So once you have become addicted to nicotine, your subsequent smoking cannot be taken as indicating your consent to the risks.

The most that we can now say with confidence, therefore, is that "cigarette smoking, at least initially, is a voluntary activity," in the words of a leading court case in this area (Brown 1987, p. 627). If there is to be consent at all in this area, it can only be consent in the very first instance, that is, when you first began to smoke. That, in turn, seriously undercuts the extent to which cigarette manufacturers can rely upon *volenti* or informed-consent defenses in product liability litigation and its moral analogues.

It does so in two ways. The first arises from the fact that many of those now dying from tobacco-induced diseases started smoking well before warnings began appearing on packets in 1966 and were

27. It begs this question to say that the one reflects an "evaluational" and the other merely a "motivational" judgment (Watson 1975; 1977) or that the one reflects a "second-order preference" and the other merely a "first-order" one (Frankfurt 1971). In the intrapersonal bargaining game that Schelling envisages, each side typically claims the superior status for its own preference ranking. From the wanton self's point of view, wanton preferences enjoy evaluational rather than merely motivational status.

hooked by the time those warnings reached them. Their consent to the risks of smoking could only have been based on "common knowledge" and "folk wisdom." That is a short-term problem, though, since that cohort of smokers will eventually die off.

The second and more serious problem is a continuing problem in a way the first is not. A vast majority of smokers began smoking in their early to middle teens. Evidence suggests that "of those teenagers who smoke more than a single cigarette only 15 percent avoid becoming regular dependent smokers" (Russell 1974, p. 255). Studies show that, "of current smokers, about 60 percent began by the very young age of thirteen or fourteen" (Blasi and Monaghan 1986, p. 503), and the great majority—perhaps up to 95 percent—of regular adult smokers are thought to have been addicted before coming of age (Califano 1981, p. 183; Lewit, Coate, and Grossman 1981, p. 547, n. 8; Pollin 1984; Leventhal, Glynn, and Fleming 1987, p. 3373; Davis 1987, p. 730; U.S. DHHS 1988, p. 397).

The crux of the matter, then, is just this: being below the age of consent when they first began smoking, smokers were incapable of meaningfully consenting to the risks in the first instance.[28] Being addicted by the time they reached the age of consent, they were incapable of consenting later, either.

## 2.3 DO THE BENEFITS OUTWEIGH THE COSTS?

In addition to Kantian-style questions about informed consent, there are also utilitarian-style questions of overall social welfare to be considered in this connection. Calculations of the social costs of smoking—both to smokers themselves and to the larger society—establish a prima facie case against smoking on such grounds, as will be shown in section 2.3.1. Before that presumptive case can be conclusive, though, we must consider two rejoinders, to be discussed in sections 2.3.2 and 2.3.3. In the end, neither is convincing, so there is a case against smoking in terms of utility as well as autonomy. But it is important to see that that case does not fall out quite so easily as we might preanalytically suppose it would.

### 2.3.1 *The Disutility of Smoking*

Presumably it is in straightforwardly utilitarian terms that public health measures of all sorts are standardly justified. We do not leave

28. Strictly speaking, ability to consent is not predicated—legally or morally—upon attaining some arbitrary age but, rather, upon having attained the capacity to make reasoned choices in the matter at hand (Anonymous 1986, pp. 812–13). The level of understanding manifested by teenagers about smoking clearly suggests that their decision to start smoking cannot be deemed an informed choice, however (Leventhal, Glynn, and Fleming 1987).



it to the discretion of consumers, however well-informed, whether or not to drink grossly polluted water, ingest grossly contaminated foods, or inject grossly dangerous drugs. We simply prohibit such things, on grounds of public health. That appeal is justified, in turn, most standardly by recourse to utilitarian calculations of one sort or another.

Of course, we might try to dress those utilitarian arguments up as something else. To some extent, the same considerations that lead us to believe that such public health measures are justified on grounds of social utility might also give us grounds for presuming people's (at least hypothetical) consent to them, also. To some extent, we can appeal to the unfairness as well as the social disutility of external costs imposed on others in order to justify public health measures: contagious diseases and costly cures affect the community as a whole, burdening others with bills they have done nothing to incur but which the perpetrators have no (narrowly self-interested) incentive to avoid, either. While bearing those other, nonutilitarian interpretations as well, those at root seem to be most naturally seen as utilitarian considerations in favor of public health measures.

To a very large extent, though, the justification of public health measures in general must be baldly paternalistic. Their fundamental point is to promote the well-being of people who might otherwise be inclined calvalierly to court certain sorts of diseases. The ultimate ethical justification for such paternalism, in turn, must be essentially utilitarian, turning on the way that overall social utility is maximized when the utilities of all members of the society are maximized.

All of those broadly utilitarian considerations are in play in the case of smoking. Paternalistic elements have been canvassed above. There are contagion effects, too (Preston 1971; Schelling 1986b, pp. 161–62): being among smokers exerts strong social pressure upon people to start smoking and makes it difficult for people to stop; and these contagion effects are particularly pronounced among young people, whose smoking behavior is strongly affected by that of parents and peers (Leventhal and Cleary 1980). As regards externalities, smoking is believed to cause at least half of residential fires, harming family and neighbors as well as the smokers themselves (Schelling 1986a, p. 550; U.S. CEA 1987, p. 185; Botkin 1988); treating smoking-induced illnesses is costly, and even in the United States some 40 percent of those costs are borne by the public (Breslow 1982, pp. 146–48; U.S. Congress, Office of Technology Assessment [OTA] 1985); premature deaths cost the economy productive members and entail pain and suffering for family and friends; and so on (Atkinson and Meade 1974; Schelling 1986a; cf. Littlechild 1986).

Dealing just in those nonquantified terms of human costs, smoking must surely stand indicted. The U.S. surgeon general says it

is "the chief, single, avoidable cause of death in our society and the most important public health problem of our time" (U.S. DHHS 1982, preface). Cigarettes kill 25 percent of their users, even when used as their manufacturers intended they be used. Suppose a toaster or lawnmower had a similar record. It would be whipped off the market forthwith. On utilitarian grounds, there would seem to be no reason why cigarettes should be treated any differently.

For those preferring hard, solid numbers, economists (focusing principally upon medical costs and lost productivity) calculate that smoking costs the American economy on net $52–$62 billion per year (Luce and Schweitzer 1978; U.S. OTA 1985; Rice et al. 1986). By that reckoning, too, there is clearly a case to answer against smoking, on grounds of social utility.

To say "there is a case to answer" is not, of course, to say that there necessarily is no adequate answer. Defenders of smoking do, in fact, offer rejoinders on two levels. One is a microlevel argument couched in terms of benefits to smokers themselves from the practice. The other is a macrolevel argument, querying the real costs to society from the practice. These rejoinders will be considered, in turn, in sections 2.3.2 and 2.3.3, respectively.

### 2.3.2 *The "Willingness to Pay" Rejoinder*

The first style of rejoinder to the standard utilitarian case against smoking operates in standard microeconomic terms, familiar from consumer theory and welfare economics. Essentially, it amounts to a repudiation of "human capital" calculations of costs and benefits in favor of a "willingness to pay" approach (Schelling 1968; 1986a, pp. 500–502; Robinson 1986).

Utilitarians tend to regard all capital in a society—including the capital embodied in your physique—as society's capital. Anything done to diminish that capital stock is therefore adjudged bad, on utilitarian grounds. At this point, though, a rights-based theorist would ask, Whose human capital is it, anyway? Unless we believe in forced labor, we must accept that even a highly productive member of the work force is perfectly entitled to quit his job and go live on a desert island, squandering his talents from which everyone else would have benefited so greatly. The rights theorist would say that we must accept, with the same equanimity, the productivity loss entailed in a person's (voluntary, fully informed) decision to smoke himself to death.[29]

29. Notice, e.g., the way Tollison and Wagner (1988, pp. x, 114) set up the problem: "Depending on whether those costs are predominantly borne by smokers or by nonsmokers, very different implications for public policy surely arise. If smokers bear the costs of their smoking, we submit that little if any issue of public policy should arise, particularly within the normative framework of the American polity as constituting a free people. But if nonsmokers bear significant portions of those costs, tobacco taxation and regulation may be important instruments for making smokers more fully responsible for the costs of their smoking." At the end of their book, having demonstrated, to their own satisfaction at least, that the former is the case, they conclude with a plea for "the liberty of tobacco consumers to act on their free choice and mind their own business. . . . If government is going to be allowed to enact coercive measures that arbitrarily restrict the liberties and trample the rights of smokers, where will employment of this restrictive power end?"



There is no need to move outside the utilitarian language of costs and benefits and over into the deontological language of rights to make this point, however. There is another, perfectly respectable utilitarian way of phrasing the same basic proposition. That is simply to say that cost-benefit calculations should take into account whatever subjective pleasures smokers derive from the practice.[30] In the boldest statement of this very standard microeconomic proposition, Buchanan (1970) argues that, if fully informed people would be willing to buy the product in preference to all others on the market, then by banning that product from the market we would necessarily be making them worse off. Or at least we would necessarily be making them worse off in terms of their preference ordering, which—for Buchanan, like most economists—equates, by definition, to welfare. It may betray a defect of character that they have such preferences; but the fact remains that they do have them, and by this account we must simply respect them (Schwartz 1989).

One quick way around this argument is to reject "willingness to pay"—and preference-based standards, more generally—as a true measure of welfare or utility. It might be argued that, in reckoning costs and benefits, we should deal in terms of interests, not wants. Sometimes, as with cigarettes, people subjectively want what will objectively harm them. To pander to their wants in such cases would compromise their welfare and undermine their utility.

Certainly there would be little difficulty in establishing health (or life, anyway) as a Rawlsian "primary good," a necessary means that is a prerequisite for accomplishing any more particular ends that people might have. In that sense, health is indeed an "interest" that people have, whether they know it or not; and their welfare (or, anyway, their stock of resources for obtaining welfare) is indeed increased by any measures protecting their health.

30. See, e.g., Atkinson 1974; Wikler 1978/1983, p. 42; Woodfield 1984, p. 118. Even in tort law, a form of "risk-utility" analysis is now standardly employed in such cases: the benefits have to exceed the anticipatable losses for an activity to be deemed nonnegligent. See Edell and Gisser 1985, for a discussion of the application of this more general doctrine to the case of smoking.

Having established that health is among a person's interests, though, that argument still crucially fails to do precisely what we need it to do for us. We need to know not only what the person's interests are but also, more important, how to trade off each of those interests for one another, if we are to be able to act effectively on his behalf. The argument just sketched, insofar as it provides guidance on this point at all, argues against according a person's health interests any kind of absolute priority over the person's other interests.

Indeed, on the argument just sketched, a person's other interests should actually override his health interests, at least occasionally. The argument, recall, was that health is necessarily in a person's interests because it is a necessary means to his other ends. But if that is the only reason a person has for valuing his health—and it is the only reason our argument says he *must* have for valuing it—then by the selfsame argument we can justify unhealthy activities, insofar as they are strictly necessary to the accomplishment of those other ends. It would obviously be absurd to let pursuit of a goal valued merely as a means to get in the way of pursuit of the ends it is valued as a means toward.

We may, then, have grounds for weak paternalism in overriding the judgments of people who irrationally profess no interest at all in their health, or who risk unnecessary harm to it in pursuit of their other goals. We have no grounds, however, for overriding the judgment of people who suppose that there are pleasures—mountain climbing, racing, skiing, smoking, or whatever—worth risking their health to pursue. As the official representative of the U.K. Department of Health and Social Security put it to the European Community Council of Ministers, when they were considering new tobacco regulations, "individuals should be free to choose their own method of death—whether from high-tar cigarettes or from throwing themselves in front of the airport bus."[31]

The short way around the microeconomic "willingness to pay" argument is thus blocked. We are obliged to take a longer path instead. One such path starts from the standard observation that cigarette sales are substantially price inelastic. Estimates of just how inelastic vary.[32] But much evidence suggests that even rather large

31. Lord Skelmersdale, quoted by Robin Cook in *Hansard's Parliamentary Debates* (Commons), ser. 6, vol. 140 (1988), col. 831. See similarly Dworkin 1972/1983, p. 33 and Wikler 1978/1983, p. 41 for more careful statements of this proposition, common in incohate form in libertarian defenses of smoking such as Machan 1986, p. 51 and Tollison and Wagner 1988, p. 114.

32. In Maynard and Kennan's (1981, p. 39) survey, they vary from zero to −1.8919, with the majority of estimates falling in the −0.35 to −0.80 range. In Britain, H.M. Treasury (1980, p. 106) employs an official estimate of −0.46. Atkinson, Gormulka, and Stern (1984, p. 53), examining patterns in the British Family Expenditure Survey for the period 1970–80, find that the price elasticity for the "typical" household is −0.60, dropping only a little (−0.46) for wealthier and higher status households and rising only slightly (−0.66) for poorer and lower status ones. Age seems to make much more difference than class. Lewit, Coate, and Grossman (1981) find that price elasticities are dramatically higher for younger smokers (−1.40 for twelve- to seventeen-year-olds; −0.89 for twenty- to twenty-five-year-olds) than for older, more established smokers (−0.45 to −0.47 for other age groups).



increases in the price of the product (induced, e.g., by increased excise taxes) result in only slight decreases in sales, at least among adult consumers.

From that fact, we might infer either of two conclusions. One would be that there is an enormous "consumer's surplus"—that is, subjective benefit, net of subjective cost—that smokers enjoy, and that even hefty taxes would not extinguish. Price inelasticity would then be taken as evidence that there are substantial subjective gains to consumers from smoking, which ought to be set off against the calculated social costs in any utilitarian decision procedure. Which would predominate we cannot say in advance. But other things being equal, utilitarians ought be more inclined to allow smoking the more satisfaction consumers derive from it.

Alternatively, we might infer from price inelasticity that people are indeed addicted to the product (Atkinson 1974; Wikler 1978/1983, p. 48; Woodfield 1984, p. 120)—and that they are somehow objectively, and not just subjectively, hooked (cf. Schwartz 1989). Present users will pay any price for cigarettes for the same reason they will pay any price for heroin: they cannot help themselves. Most of them, when asked, report getting relatively little subjective pleasure from smoking (Kozlowski et al. 1989). Most of them would rather not smoke, surveys show. Most wish they were not hooked, but they backslide almost every time they try to get unhooked. In that case, "the willingness of people to buy cigarettes does not genuinely reflect the value they place upon cigarettes" (cf. Tollison and Wagner 1988, p. 38).

Admittedly, there is a bit of a problem in determining what should count as a "benefit" to addicts. In one sense, they benefit from having their habits serviced—certainly they would suffer in some obvious sense otherwise. So in a way, the implication of the addiction interpretation would be much the same as that of the consumer surplus interpretation, that is, present users benefit, as indicated by their willingness to pay, from smoking. In another way, however, they would benefit—even in terms of subjective preferences—if they were to stop. In the same terms, others would benefit if they were never to start.

The point, here, is simply that addictive substances are not ordinary economic goods. Ordinarily, cultivating new tastes (acquiring a taste for fine foods, e.g.) is thought to make you better off, in the sense of being able to derive more pleasure, or whatever, than before. With addictions, however, you are worse off, even in your own eyes, than before (Stigler and Becker 1977); whatever momentary pleasures you derive from servicing the addiction, you would prefer to stop but find that you cannot. Thus, we should do whatever we can to prevent new addicts, who would be subjectively worse off once addicted than they were before (Sunstein 1986, pp. 1158–61, 1170; 1988, pp. 282, 290).

As regards existing addicts, the most we can say is that there may be a humanitarian-cum-utilitarian case to be made for continuing to service their addictions (Oken 1985; Lundberg and Knoll 1986). Even they would be subjectively better off in the long run, though, if they could be helped to break the addiction (Schelling 1986a, p. 552). We know that simply because that is how addiction is here defined: as trying to break the addiction, and failing. And we know, from the empirical evidence cited in section 2.2.2 above, that most smokers are addicts in this sense.

### 2.3.3 *The "Overestimate of Net Social Cost" Rejoinder*

The first "willingness to pay" rejoinder to utilitarian arguments for curbing smoking alleges, in effect, that those arguments underestimate the benefits consumers derive from smoking. A second sort of rejoinder alleges that those utilitarian arguments for curbing smoking overestimate the net costs that accrue to society from people's smoking.

The less interesting versions of this argument point to the tobacco industry's contribution to the national economy. Estimates of the annual contribution of the tobacco industry to the U.S. gross national product (GNP) vary wildly, from 3.3 billion (Gray and Walter 1986, p. 254) to 31.5 billion (Chase Econometrics 1985). The latter estimate, in a report commissioned by the Tobacco Institute from Chase Econometrics, is particularly suspect, for as its authors themselves say "without the tobacco industry, the expenditure on, and resources devoted to the production of tobacco products would simply be shifted elsewhere in the economy. . . . The compensatory responses that would occur automatically within the economy and within the Chase Econometric U.S. Macroeconomic Model in a total impact-type of study were [deliberately] constrained from taking place in this analysis" (quoted in Warner 1987, p. 2083). Still, even on that high estimate, the tobacco industry contributes only $31.5 billion to the U.S. GNP. Set off against the $52–$62 billion cost estimates described above, that still leaves the industry's account well in the red.



A more interesting version of this argument alleges that the above procedures overstate true social costs. As regards the narrow question of health care costs, everyone dies of something sooner or later. For an accurate assessment of the medical costs of smoking-related diseases, then, we must deduct the costs that would have been incurred had the people killed by smoking died of something else later (Wikler 1978/1983, p. 46). In terms of hospital-bed days and overall medical expenditure, over the course of their lives as a whole, there is some evidence to suggest that there may be no significant difference between smokers and nonsmokers (Leu and Schaub 1983; Weinkam, Rosenbaum, and Sterling 1987; cf. Rice et al. 1986, pp. 502–4).

Similarly, perhaps we need not worry too much about externalities, in the sense of the unfair imposition of burdens on others. Smokers could be refused treatment in public hospital beds and made to pay their own way. They could be required to carry complete insurance against smoking-related diseases; and to avoid unfairness to coinsureds, we could further require that risks to smokers be pooled only with those of other smokers (Wikler 1978/1983, p. 49), as is increasingly done by insurance companies for purely commercial reasons anyway. Alternatively, we might correct unfair external costs that smokers impose upon society at large by imposing a special tax on tobacco products. The basic idea here would be for "users of cigarettes . . . to pay an excise tax, the proceeds of which would cover the costs of treatment for lung cancer and other resulting illnesses" (Wikler 1978/1983, p. 49; see also Garner 1977; and Gewirth 1980, p. 125; Feinberg 1984, p. 25).

In a certain very narrow sense, it might be said that smokers already "pay their own way." A special "excise tax" is presently levied on tobacco, and substantial sums are generated in that way. In the United Kingdom, the cigarette tax annually accounts for 4–5 percent of total tax revenue, down from 8 percent in 1965, but nonetheless a hefty sum (Godfrey and Maynard 1988, p. 342; Preston 1971). Such sums go a long way toward reimbursing society for the costs of smoking. It has been estimated that in Ontario it takes only 8 percent of tobacco tax revenues to pay for all public health care expenditure on smoking-related disease (Stoddart et al. 1986). Even in the United States, if we count only the share of health care costs borne by the federal government, that is almost exactly counterbalanced by the federal excise tax on cigarettes (U.S. OTA 1985).

Those calculations work on a very narrow base. Perhaps the tobacco tax typically pays all the medical expenses borne by the government. Those are not the only costs to society from smoking, though; and the tobacco tax would not come nearly so close to covering the external costs of smoking if we were to include all of them (e.g., lost

productivity) in that account. In principle, the solution here is straightforward: simply raise the excise tax however much it takes to meet the bill. In practice, of course, that may prove politically difficult.

Beyond all that is the larger question of whether a mere excise tax is, even in principle, capable of addressing fully the issues of external cost that matter to utilitarians. Suppose the tax is high enough to generate sums sufficient to cover the full external costs to society from people's smoking. Then it certainly is true that society as a whole will be no worse off, in global terms, as a result of smoking. With ordinary excise taxes, though, there is no guarantee that the monies collected through the tax will be used to put right the damage done by smoking. Typically, excise tax revenues are just dumped into the government's general funds, without being earmarked to be spend for any purpose in particular. (An interesting exception is the Australian state of Victoria, where under sec. 32 of the Tobacco Act of 1987 a 5 percent levy on tobacco sales is paid into a trust fund earmarked for health promotion [Gray 1989]; in a 1989 referendum, California voters approved a twenty-five-cent increase in the cigarette tax, to be similarly earmarked for health promotion [*International Herald-Tribune,* November 10, 1989, p. 2].) We justified the collection of those tobacco taxes on the grounds that smoking increases demand for cancer wards in hospitals. But, in the absence of earmarking, we might end up spending the monies collected on sports stadia or aircraft carriers (U.S. DHHS 1989, pp. 536–39).

Joel Feinberg (1984, p. 25) thinks it does not matter. "Even if the tax revenues extracted from smokers go into a general fund, the effects would be almost the same as if they were earmarked for costs directly connected with smoking, for more funds would be available from the general fund for those special purposes" of remedying the harms caused by smoking. But to say that more funds would be available for those other smoking-related problems is not, of course, to say that they will necessarily be spent on solving those problems.

So far as Treasury economists are concerned, this is as it should be. They standardly boast of the efficiency of general fund financing. What they mean by saying that is simply that it allows funds to be shifted to the most urgent needs, as required. And, on certain narrow understandings of what utilitarianism is all about, efficiency of this sort is all that ought matter in those terms.

There is no reason to take quite so narrow a view of what utilitarianism requires, however. There is no reason, in utilitarian logic or anywhere else, for supposing that people (and hence societies made up of those people) either do or should have any simple form of utility function. They may derive satisfaction not only from their overall utility score but also from its composition. They may want not only to maximize utility but also to derive their utility from diverse



sources and amusements, for example. Or, for another example more pertinent to the smoking issue, they may want certain funds to be spent in certain ways, regardless of the inefficiency that that might entail. It is perfectly possible that people have a richer texture to their utility functions in all these ways (Sen 1977; Goodin 1989). Insofar as they do, earmarked excise taxes may be required to maximize utility. As individuals, we care not only about the size of our income but also about how it is spent. So too, as a society, we care not only that enough money comes in through taxes to cover costs; we also care how that money is spent.

Specifically, we might think that if any special tax is to be levied against a particular product on account of damage it does, those who have been damaged by that product ought be the ones to benefit from the tax monies thus raised. One way to phrase the point would be in terms of fairness: it is unfair for people to impose external costs on others; by the same token, it is unfair to recoup those external costs but then not recompense those who suffered them. Now, "fairness" may not in and of itself be a utilitarian concern. (That is arguable both ways, but let us leave that problem to one side here.) The point here is simply that if people do internalize that standard of fairness for one purpose, the strain of consistency would press them to internalize it for both purposes. If they do, then to maximize their utility we must earmark tobacco excise taxes for use by the health services.

Economists are generally implacably opposed to earmarking taxes. Sometimes, however, they can be reconciled to it, when it serves as a surrogate for "user fees" for public services. The prime example is the gasoline tax, collected from road users, being earmarked for building and repairing the roads that they use. The point of imposing earmarked taxes, recall, is to overcome the problem of external costs. To avoid the opposite problem—that of imposing taxes-cum-user-fees on people in excess of the costs of the services used—those taxes must pass various tests. All users of the publicly provided service, and only users of that service, must pay the tax; the tax that they pay must be proportional to the amount of the service that they use; their benefits from the service must be proportional to the sacrifices entailed for them by the tax; and so on.

Some taxes-cum-user-fees come tolerably close to passing all those tests. The gasoline tax is a classic case in point.[33] The earmark-

33. Virtually all drivers of motorized vehicles consume gasoline; and, with certain exceptions (primarily drivers of off-road vehicles, like farm tractors and snowmobiles), only they consume the taxed gasoline. There is some variation in fuel efficiency between different vehicles, but broadly speaking drivers pay gasoline tax roughly in proportion to the number of road miles driven. Those who drive less fuel-efficient luxury sedans are, by and large, richer people whose time is worth more to them and

ing of tobacco taxes would not, however. To a large extent, the treatment of smoking-related diseases is not a publicly provided service at all, in certain places: in the United States, for example, it would be primarily for those old enough for Medicare or poor enough for Medicaid or some equivalent state program; others, generally, would have to finance treatment from private sources. Even where health care is a public responsibility (as under the British National Health Service), smokers are not the only ones to use lung cancer wards, and users of those cancer wards are only a subset of all those who smoke. Furthermore, some smokers pay the taxes without ever using the service, while others use the service having paid the same (or perhaps less) in taxes.

In part, this latter disparity can be rationalized by reconceptualizing the "service" in question as "medical insurance" rather than "treatment in cancer wards." Even then, there is no reason to believe that those who smoke the most, and hence pay the most in tobacco excise taxes, are also those who are the most averse to taking risks. That is what would be required, if we are to equate the benefit they derive from the insurance with the sacrifice they have made in paying the taxes. But, if anything, the opposite is more likely to be true: those who smoke most, and hence pay the most in tobacco taxes, are probably the most insensitive to risks, and hence value insurance least.

Friends of the tobacco industry seem to welcome the conclusion that earmarked taxes on tobacco consumption are unacceptable (Tollison and Wagner 1988, pp. 56–61). Yet that is curious. For if we object to the unfairness of external costs imposed by smoking, and if we cannot remedy that unfairness by any technical gimmick like earmarked taxes on tobacco, then we have no recourse but to try to reduce the unfairness by reducing tobacco consumption itself.

Decidedly the most interesting variation on the general theme that smoking costs society less than we think, though, is one that argues that smokers save us money by dying early. Just think: "smoking tends to cause few problems during a person's productive years and then to kill the individual before the need to provide years of social security and pension payments. From this perspective, the truly burdensome individual may be the unreasonably fit senior citizen who lives on for thirty years after retirement, contributing to the bankruptcy of the social security system, and using up savings

hence who would benefit most from faster roads; so those who are charged disproportionately more for use of the roads are those who benefit disproportionately (and, incidentally, those to whom any given dollar's tax would constitute less of a sacrifice, assuming the marginal dollar means less to the rich than to the poor).



that would have reverted to the public purse via inheritance taxes, had an immoderate life-style brought an early death" (Wikler 1978/1983, p. 46; see also Warner 1987b; Gori, Richter, and Yu 1984; cf. Schelling 1986a, pp. 556–57). And lest this proposition be regarded as altogether frivolous, I hasten to add that these considerations were taken very seriously indeed in the 1971 report of an interdepartmental committee of U.K. civil servants assigned to draft a smoking policy (Philips 1980); they figure from time to time in letters to the editor of the *New York Times* (quoted in Troyer and Markle 1983, p. vi); and so on.

In the eyes of many, however, this argument will appear to be a reductio ad absurdum. What it seems to suggest is nothing less than a thinly veiled form of not-altogether-voluntary euthanasia. Many suppose it is unjust, if not necessarily uneconomic, to encourage people to die off promptly upon their ceasing to be productive members of the work force (cf. Battin 1987).

What this is a reductio of, however, is not the utilitarian calculus but, rather, an economic calculus that serves as such a poor proxy for it. Most people who are already retired would wish to enjoy a long and happy retirement; most people still in the work force would wish the same for themselves and, indeed, for their elders. Those preferences, too, must be factored into any proper calculus of social utility. Once they are, early deaths induced by smoking are almost certain to turn out to be costs rather than benefits in the broader social scale of values.

Indeed, in light of those preferences, perhaps what we should regard as an external social cost is not being *able* to pay pensions to the prematurely deceased rather than having to pay pensions to those who live to a ripe old age. In the slightly purple prose of Schelling (1986a, p. 557), "We do not hope that 60-year-old fishermen die at sea, that 60-year-olds neglect seat belts and die in their automobiles, or that 60-year-old marital difficulties lead to suicide or homicide. . . . That people who die at retirement age bequeath more than they cost" is irrelevant to our assessment of their deaths as tragedies, and so too with smokers. "We would not be true to our own values if we . . . excused [their] smoking and let them die to our benefit. That is simply not the attitude that we take toward untimely death."

## 2.4 POLICY OPTIONS

Insofar as we are impressed with the case sketched above against smoking, in terms of harms to smokers themselves, the goal of social policy ought be to curtail smoking altogether. We have six broad policy options available to us for doing so.

### 2.4.1 *Self-regulation*

Tobacco companies could be encouraged to restrict voluntarily their own activities, refraining from advertising in certain ways and from selling to certain people (e.g., children). This, of course, is the companies' preferred option; and it is one that is still relied upon, albeit decreasingly (or as a precursor to legislation), in over a third of the Organisation for Economic Co-operation and Development (OECD) and in many other countries around the world (Cox and Smith 1984; Roemer 1986). Self-regulation is elevated to an art form in Britain and Australia, particularly, where most advertising and promotion of tobacco products is restricted by no more than a set of "voluntary agreements" between the industry and the government. In Britain, even warning labels are the subject of mere voluntary agreements (Taylor 1985, chap. 5; Baggott 1986).

These strategies are doubly flawed. First, it is doubtful that the agreements in question are fully voluntary. Typically they are—and apparently can only be—extracted from the industry under threat of legislation compelling compliance with government wishes, if "voluntary" agreement is not forthcoming. Tobacco companies in the United States announced a "voluntary code" to regulate their advertising only after the U.S. Federal Trade Commission had already published in the *Federal Register* its own rule on the matter, to take effect in six months' time (Fritschler 1969, p. 99). Similarly, successive British health ministers have been perfectly frank about the threat of legislation as the only mechanism that is really effective in securing voluntary agreements. David Owen, in his days in that post, went so far as to have the threat printed in *Hansard* in a written reply to a parliamentary enquiry, explaining later, "A minister needs to know before he goes into negotiations, and the industry needs to know it too, that he has the power to legislate. Then you can have a serious discussion" (quoted in Goodin 1986, p. 440).

Agreements extracted under duress, however, are not voluntary in any sense that contributes to the moral legitimacy of their enforcement. That is a standing rule of contract law, for example. And friends of the tobacco industry are quick to draw the parallel to the case of "voluntary agreements" extracted from it through such coercive threats. In a 1976 parliamentary debate, for example, one pro-tobacco Member of Parliament argued:

> I do not believe that the agreement with the tobacco industry is entirely voluntary. When a Minister goes to an industry and says that he wants an understanding, that he wants some progress, he knows, and the industry knows, that he has in his pocket proposals for legislation, or rules, or regulations, which, in effect, say that if the industry does not do what the Government want, the result will be achieved by the use of compulsory powers. . . . I do not think in this case that my hon. Friend can claim to have a voluntary agreement with the tobacco industry. He has its reluctant consent, but no more than that. [Quoted in Goodin 1986, p. 442]



The point seems to me a perfectly fair one. Agreements concluded under duress just do not count, morally.

It would be wrong to conclude from that, however, that governments have no right to regulate the tobacco industry. The proper inference is merely that "voluntary agreements," concluded under threat of legislative compulsion if agreement is not forthcoming, do not add anything to the moral legitimacy of such regulations. Either it is morally permissible for governments to legislate along those lines, or it is not. If it is impermissible for them to legislate, then it is not permissible for them to threaten to legislate in order to extract "voluntary agreements," either; and any agreements extracted in this way are null and void. For it to be permissible for governments to threaten legislation in order to extract voluntary agreements, it must antecedently have been permissible for governments to legislate such regulations even in the absence of agreement. In short, voluntary agreements extracted in this fashion are morally superfluous. If a government has moral authority to extract agreements in this fashion, it has no need for such agreements: it has had the moral authority to impose the regulations without the industry's agreement, all along (Goodin 1986).

There is a second and more practical flaw with self-regulation strategies. That is simply that self-regulation is, to a large extent, tantamount to no regulation. There is anecdotal evidence aplenty to support this conclusion. Frequent and flagrant violations of the spirit—and sometimes even the letter—of voluntary agreements are reported, with little apparent effect, in both Britain (Taylor 1985, chaps. 6–8; Roberts 1986; Wilkinson 1986, chap. 10; Sherman 1988) and Australia (Coleman 1985). Despite a voluntary agreement on sports sponsorship in Britain, for example, televised coverage of tobacco-sponsored sporting events referred to the sponsoring companies, verbally or visually, on average once every three minutes (Lazarus 1989). And so on.

This outcome is unsurprising. Those charged with monitoring compliance with voluntary agreements with the tobacco industry find themselves involved in a continuing relationship with a very few firms in a single industry. Naturally, no one wants to rile those with whom he must continue to deal. In their study of 101 agencies regulating

Australian business, Grabosky and Braithwaite (1986, chap. 15) found that it was precisely these conditions that made regulators reluctant to seek criminal sanctions against firms, even when they were empowered by law to do so. This combines with the institutional structure characteristic of "voluntary agreement" regimes to inhibit serious enforcement: one cannot help suspecting that the complacent tone of the British report of the Committee for Monitoring Agreements on Tobacco Advertising and Sponsorship owes at least as much to the fact that the committee was half composed of representatives of the tobacco industry as it does to the fact that it could confirm "only" forty-one of the 462 breaches in the voluntary agreements alleged in complaints to it (Lazarus 1988, pp. 2, 5).

The policy goal specified at the outset of section 2.4 was straightforward: curtailing tobacco consumption. In this connection, it is particularly important to note the results of a systematic comparison of fifteen OECD countries' experience, showing that those countries relying upon legislation have reduced tobacco consumption by almost consistently twice as much as have those relying upon self-regulation and voluntary agreements alone. The explanation seems to be that "the countries which have adopted a legislative approach to smoking control not only tend to have implemented a wider range of measures than their voluntary counterparts, but these measures are usually enforced much more stringently" (Cox and Smith 1984, p. 578).

In short, it seems to be both bad morality and bad policy to rely upon voluntary agreements to regulate any important aspects of the tobacco industry. Self-regulation by the industry itself is simply unreliable and, morally, there is no reason we should have to rely upon it.

### 2.4.2 *Torts*

Paralleling self-regulation on the part of the tobacco industry would be a policy of self-help on the part of those injured by that industry. After all, tobacco companies—like all other members of the community—are responsible, legally, for any damage that they do to others. Such legal liability has nothing to do with recent legislation. It derives, instead, from ancient principles of that branch of common law known as "tort law."

Tort suits against cigarette manufacturers, demanding compensatory damage payments for wrongful death and injury done to smokers of their products, grew increasingly common through the 1970s and 1980s. It was long thought that these suits were on solid legal ground. It was standardly said to be only a matter of time before one succeeded. It was widely expected that, once one such suit succeeded, countless other victories would follow in fairly short order.



At that point, "cigarette makers may be held accountable for an estimated $80 billion a year in smoking, . . . saving millions from premature death" (Tribe 1986, p.788).

Naturally, such perceptions and predictions were common currency among attorneys active in litigation against tobacco companies on behalf of victims of smoking (Garner 1980; Edell and Gisser 1985; AMA 1986; Daynard, Popper, and Gruzalski 1986; Daynard 1988). But they are biased. Perhaps a better (because more impartial) measure of the widely perceived likelihood of large numbers of successful tort suits is the discount that financial markets have been applying to tobacco company stocks in recent years. In 1987, they seem to have been valued over 35 percent less than they should have been worth, on the basis of the companies' profit/earnings ratio alone (Cohen 1987, p. 5).

Now the landmark has been established, in the case of *Cipollone v. Liggett Group, Inc.*[34] In their June 1988 verdict, the trial jury in that case awarded $400,000 in damages to Antonio Cipollone, whose wife, Rose Cipollone, died of lung cancer in 1985, aged fifty-eight. This case has dragged on for five years already; with the defendants threatening to appeal, it may well drag on for a fair while longer before the final decision is rendered. Still, this victory will give heart to other victims of smoking-related diseases to bring yet more suits, in addition to the hundred or so pending at the time of the *Cipollone* decision. Hence we can expect an increasing barrage of tort liability suits against tobacco companies in the coming years, whichever way Liggett's appeal eventually goes.

It is obviously desirable that those who have been harmed should recover damages from those who have harmed them, wherever possible. Tort litigation is a very imperfect as a general solution to the problem of smoking, however. The problems that plaintiffs have heretofore experienced serve to indicate something of the limits that will continue to plague this as an overall strategy, even after a legal beachhead has finally been firmly established (Garner 1980; Daynard 1988).

Central to a tort claim is proof of causation. Even under the sternest rules of liability, plaintiffs can recover against someone only if they can prove that that agent caused the harm that they suffered. Typically, cancers admit of multiple causes and arise only after long latency periods. Any given cancer might have been caused by smoking, by workplace contaminants, by genetic endowment, or by some

34. Civil Action no. 83–2864, U.S. District Court for the District of New Jersey. For reports of the verdict, see Janson (1988) and Cipollone v. Liggett Group, Inc., 693 F. Supp. 208, 210 (D.N.J. 1988).

combination of all of these. In tort law, of course, the standard of proof is merely "more probable than not"; so plaintiffs do not have to prove "beyond a reasonable doubt" that cigarettes caused their cancer. But proving that they are twice as likely as anything else to have caused it (which is what the 50 percent rule often comes down to) might be almost as arduous.[35]

What we should be doing, of course, is apportioning blame among all causal factors, and assessing fractional liability to each. If there are four things that contributed 25 percent each to a plaintiff's cancer, each defendant should be required to pay 25 percent of the award that the plaintiff would have secured had there been but a single cause. Similarly, if it is 25 percent likely that smoking caused a plaintiff's cancer, the plaintiff should recover 25 percent of damages from the tobacco company regardless of the relative probabilities of other causes (Rosenberg 1984; Thomson 1986, chap. 12).

Moves toward some such model of "attributable risk" and "assigned share" are now afoot. A powerful "tort reform" counterrevolution is also afoot to upset them (Schuck 1988). In any case, this model may not prove to be a very successful strategy for recovery by individual plaintiffs, who may find it founders on problems of inferring from aggregate data to facts about particular cases (Thomson 1986, chaps. 12 and 13). "Sure," defendants' counsel will say, "in general the statistics are as the plaintiff says; but we are not being sued by a statistical artifact but rather by a particular person. How are we to know that what is true in general is true of this person in particular?" Plaintiffs can go some way toward meeting demands for particularized evidence by factoring into the equation all their personal case histories (family background, work history, etc.). But this still falls somewhat short of ideally individualized evidence of person-to-person harm, of the sort paradigmatic in torts (e.g., in an auto crash) (Schuck 1988, pp. 103–4). Some juries, rightly or wrongly, will no doubt balk at such evidence, refusing to compensate some people whom statistically they should.

There are various ways around such problems (Garner 1977). One is to use aggregate-level statistical evidence to generate a "rebuttable presumption" that smokers' cancer is caused by their smoking, unless defendants can prove otherwise in any given case. (The Black Lung Benefits Act of 1972 imposed a similar rebuttable presumption

35. Even in the *Cipollone* case, which was straightforward as these go, "the jury heard a series of medical witnesses who disagreed on Mrs. Cipollone's cancer. The defense experts said it was a typical carcinoid, a form they said was not statistically associated with smoking. Mr. Cipollone's experts said it was small-cell cancer caused by cigarette smoking. They said smoking produced both types of cancer," in any case (Janson 1988, p. B4).



against mine owners.) A second alternative is to have victims of smoking-related diseases transfer their tort claims to welfare agencies bearing the costs (medical care, disability/survivors' benefits, etc.) of their illnesses; welfare agencies can then mount tort suits against manufacturers for the total aggregate harm done by smoking, and in such suits aggregate-level statistical proof is obviously relevant in a way it might not be in case-by-case adjudication. (The Social Security Amendments of 1974 similarly require deserted mothers receiving Aid to Families with Dependent Children [AFDC] to transfer their claims to child support to welfare agencies, who are then responsible for recovering payments from delinquent fathers.) How far either strategy can or will be applied against cigarette manufacturers remains to be seen, though.

Then there is the further matter of "negligence." Of course, we might argue that tobacco companies should be held strictly liable for anything that happens when people consume their products. They had the capacity to test them in the laboratory, in a way that consumers could not have done. If using the product as intended kills 25 percent of its users then there is a case for considering it an "ultra-hazardous product," and for imposing strict liability in consequence (AMA 1986; cf. Anonymous 1986).[36]

Failing that, victims will be able to claim compensation only if they can prove that manufacturers were somehow negligent. Where the old-fashioned rule of "contributory negligence" still prevails, plaintiffs would also have to prove that they were not themselves negligent in any way—that they were not in any way responsible for the harm that befell them. That, obviously, is a tall order; increasingly, it has been seen as too tall an order, and states have shifted to a rule of "comparative negligence" instead. Still, in half the states, those new rules are written in such a way that, if the plaintiff is more negligent than the defendant, he cannot recover anything at all.[37] That law is ludicrous, in the same way (but only half as badly) as the "contrib-

36. Paradoxically, strict liability is imposed for "design defects" (failing to manufacture a product according to specifications) but not for defective designs. Surely the systematic infliction of damage is worse than the intermittent infliction of it, though (cf. Anonymous 1984).

37. Cohen 1987, p. 9. New Jersey is one such state, and the plaintiffs in *Cipollone* were caught in just this trap: while the deceased woman's husband was awarded $400,000 in damages, Rose Cipollone herself (through her estate) was awarded none. The jury found that she knew about the dangers of smoking "from reading and other notifications" to a sufficient extent that she could be said to have " 'unreasonably encountered a known danger' by insisting on smoking"; and they accordingly "assessed her 80 percent of the blame for her death and 20 percent to Liggett. Under the [New Jersey] law, she was not entitled to damages, unless the company had been found to be at least 50 percent to blame" (Janson 1988, p. B4).

utory negligence" rule it supplanted was ludicrous: it says that a plaintiff who bears 51 percent responsibility for harm that has befallen him must bear 100 percent of its costs, when the logic of the rule change should surely have led us to say he should bear merely 51 percent of the costs. Still, that is the law in half the states now.

To establish negligence on the part of cigarette manufacturers, plaintiffs will have to prove that there was information about health hazards of smoking that tobacco companies knew or should have known that would have led a reasonable man to take precautions in the manufacture and sale of the product (including, ultimately, withdrawing the product from the market). Such arguments might go a long way, just on the basis of what tobacco companies should have known about the hazards of smoking from the published scientific literature. Even more compelling, though, are arguments based on companies' own early in-house research showing the carcinogenic properties of tobacco smoke: it is very difficult for companies to claim that they did not know of the evidence, or that they gave it no credence, when it came from their own scientists. Much was made in *Cipollone,* for example, of a 1961 "confidential limited" report prepared by Arthur D. Little, Inc., who had done mouse-skin cancer experiments for Liggett and Meyers, that opened with the words: "1. There are biologically active materials present in cigarette tobacco. They are a) cancer causing b) cancer promoting c) poisonous d) stimulating, pleasurable, and flavorful."[38]

These internal company documents, obtained in the course of litigating *Cipollone,* are now in the public domain and are available for use by subsequent litigants in other cases. Subsequent juries might—in a way the *Cipollone* jury refused to do—construe them as evidence of "reckless disregard" for customer safety in the face of compelling evidence of probable harm. Then there would be grounds for a judgment of "intentional tort" and the award of punitive damages. (There might even be grounds for prosecution for criminal assault or manslaughter, although that day still seems fairly distant.) While the *Cipollone* jury did not buy this argument, the trial judge in that case refused the defendant's plea to quash it altogether. In his view, more than enough evidence had been produced from the company's files to show what he called "a callous, wanton, willful and reckless disregard" for the health of consumers and that tobacco companies had "entered into a sophisticated conspiracy . . . to refute, undermine and neutralize information coming from the scientific and medical community and to confuse and mislead the consuming public. . . . If the jury accepts the plaintiff's version . . . , it is difficult to envision a more compelling case for an award of punitive damages" (Sarokin 1988, 1492–93, 1500; Bremner 1988). The *Cipollone* jury itself rejected the plaintiff's claims on the conspiracy and fraudulent misrepresentation issues. It is too early to say whether others, looking at the same documents, will do likewise. This first indication is not encouraging, however (Shipp 1988).

38. "L&M—a Perspective Review," p. 1. This document was released in connection with litigation of Cipollone v. Liggett Group (U.S. District Court for the District of New Jersey, Civil Action no. 83–2864) as Plaintiff's Exhibit P-367. See, more generally, Bremner (1988), Gray (1988), Mintz (1988a; 1988b), and Janson (1988).



What the *Cipollone* case turned on, in the jury's mind, seems to have been merely "failure to warn" and "warranty" aspects of the case. When Rose Cipollone started smoking in 1942, she chose the brand that was then being widely advertised under the headline: "Play safe—smoke Chesterfields." She switched in the 1950s to L&Ms, then advertised as "just what the doctor ordered." Such advertisements seem to have constituted a manufacturer's warranty guaranteeing the safety of the product. It was breach of this warranty, and failure to warn, instead of their products' dangers, that lost the case for Liggett (Rothenberg 1988; Janson 1988, p. B4).

What bodes worse still for the prospect of widespread litigation, the *Cipollone* jury was allowed to consider the adequacy of company warnings only prior to 1966. At that point, government-mandated health warnings began appearing on cigarette packets. They were very weak warnings, arguably wholly inadequate to convey the full sense of the risks involved. But under the U.S. Constitution, federal law "preempts" state law—tort law, among it—in cases of conflict (U.S. Constitution, article 6, sec. 2). Thus, if the U.S. Congress, in mandating the printings of health warnings, had intended to exempt cigarette manufacturers from any further liability for failure to warn of risks, then tort claims under state common law arising from the inadequacy of post-1966 warnings would be constitutionally precluded. Whether or not that was the intention of Congress is indeed questionable, but the current run of court of appeals opinions (yet to be tested, as eventually they will be, in the Supreme Court) seems to favor the "preemption" defense protecting tobacco companies from post-1966 claims.[39]

39. The legislative history suggests that, while Congress intended to prohibit states from requiring any further warnings, it did not prohibit companies from printing them voluntarily—nor did it intend to relieve them of ordinary tort liability if they did not do so, when reasonable people would have done (Garner 1980, pp. 1453–54; Edell and Gisser 1985; Tribe 1986). The "preemption" argument has been accepted by three circuits of the U.S. Court of Appeal, however, including the circuit in which *Cipollone* was tried: Cipollone v. Liggett Group, Inc., 789 F.2d 181 (3rd Cir. 1987); Stephen v. American Brands, 825 F.2d 312 (11th Cir. 1987); Palmer v. Liggett Group Inc., 825 F.2d 620 (1st Cir. 1987).

In short, the products liability approach to controlling smoking through the tort law is perfectly laudable. But it is a very imperfect solution to the overall problem. There are not enough people who have well-documented cancers of the right kind to stand up in court. There are not enough of them whose cancer can convincingly be traced to pre-1966 smoking patterns. Finally, the damage awards are not large enough really to scare tobacco companies, judging from the *Cipollone* precedent. As one financial analyst put it, "Industry earnings hit a record of $3.45 billion in 1985, the last year for which industry figures are available. . . . If they are only going to be hit with awards of $400,000, the impact of these cases is not going to be very significant" (Eichenwald 1988).[40]

### 2.4.3 *Taxation*

Taxing tobacco is a particularly popular way of controlling smoking overall, in the United States, Britain, and elsewhere. Judging from the evidence (summarized in section 2.3.2 above) about the price inelasticity of cigarettes, tax-induced price rises alone may do little to curb smoking among existing adult users. Of course, it is dangerous to estimate the effects of large-scale changes by extrapolating from the effects of small-scale variations.[41] But the order of magnitude of probable effects of dramatically increased taxation is effectively indicated by British calculations, assuming an elasticity around -0.5, that it would take more than a 50 percent increase in cigarette prices to reduce cigarette sales by even 20 percent (Atkinson and Townsend 1977, p. 492).[42]

40. Daynard (1983, p. 9) argues that the costs of defending such actions might in and of itself force up the price of cigarettes, and hence reduce consumption; he points to a successful defense of a single smokeless tobacco products liability case in 1986 estimated to have cost $15 million, which swamps the mere $400,000 awarded to Antonio Cipollone in damages. But that argument cuts both ways. The plaintiff's attorneys in *Cipollone*, who took the case on a contingency fee basis, are estimated to have spent $2 million in lawyers' time and expenses over the course of the five years it took to bring the case to trial, with a share in the $400,000 damage award as their recompense. Although they can reuse much of the material prepared for that trial in subsequent litigation, the firm will have to win quite a few $400,000 verdicts to recoup such expenses.

41. The standard methodological worry is that the relationship might not be linear, very much higher prices having either much larger or much smaller effects on consumption, penny-for-penny, than only marginally higher ones. So, too, might the political reaction vary according to the size of the price rise. Cox and Smith's (1984, p. 578) fifteen-nation study of income and price elasticities confirms our fears that "a 'pricing-out' strategy towards smoking control will meet with increasing resistance amongst established smokers."

42. Of course, publicity attendant upon increases in tax levies might indirectly serve to remind people of health risks, and in that way, too, reduce smoking. That is how Leu (1984) explains his interesting finding that smokers' behavior reacted strongly to nominal increases in Swiss cigarette prices induced by tax hikes, even though in inflation-adjusted terms they constituted little or no real increase in prices.



What tax-induced price rises might do is make the habit substantially less attractive to teenagers not yet addicted to the drug. Precisely the same people whom we most want, on grounds of "informed consent," to prevent from starting to smoke are those who are least able to afford more expensive cigarettes. This a priori expectation is borne out by evidence that demand for cigarettes among teenagers is more than three times as elastic as among adults, on average; and any given price increase is almost six times more likely to make teenagers stop or never start smoking than it would adults (Lewit, Coate, and Grossman 1981). By such reckoning, it has been calculated that leaving the U.S. federal excise tax on cigarettes at sixteen cents, rather than letting it revert to eight cents as previously planned for 1985, has resulted in 1.9 million fewer people smoking in the United States, "including more than a million fewer under age 25" (U.S. CEA 1987, p. 185).

Morally, the issue is presumably whether it is permissible to use the instrument of taxation for purposes of reducing consumption of a good in such ways. After all, the purpose of taxation is to raise revenue. Some would say that using the instrument for any other purpose is simply inappropriate. At most, they would say, it might be a happy coincidence if as a by-product of raising revenue by taxing drugs their consumption falls.[43]

Certainly it is true that taxation always needs to be justified. The power to tax is the power to destroy, after all. It is also true that the state's need for revenue to pursue its legitimate purposes provides one such justification. It is not the only possible justification, though.

Mill (1859/1975, p. 123) says that "to tax stimulants for the sole purpose of making them more difficult to be obtained, is a measure

43. Mill (1859/1975, pp. 123–24), thus, writes: "It must be remembered that taxation for fiscal purposes is absolutely inevitable; that in most countries it is necessary that a considerable part of that taxation should be indirect; that the State, therefore, cannot help imposing penalties, which to some persons may be prohibitory, on the use of some articles of consumption. It is hence the duty of the State to consider, in the imposition of taxes, what commodities the consumers can best spare; and *a fortiori*, to select in preference those of which it deems the use, beyond a very moderate quantity, to be positively injurious. Taxation, therefore, of stimulants, up to the point which produces the largest amount of revenue (supposing that the State needs all the revenue which it yields) is not only admissible, but to be approved of." Wikler (1987, pp. 334–35) offers a similar, albeit less subtle, double-effect argument designed to show that taxing tobacco to raise revenue is not coercive whereas taxing it to reduce consumption is, even if both taxes have the identical effect of reducing consumption by raising the price.

differing only in degree from their entire prohibition; and would be justifiable only if that were justifiable."[44] Strictly speaking, that proposition is not quite right. The difference of degree might matter. We might be morally justified in partly destroying something, without being justified in destroying it completely.

The larger point, however, is that sometimes we *are* justified in destroying, in whole or in part, some sort of product or activity. The arguments in the previous sections of this chapter suggest that this is the case with smoking, in particular. The same arguments that justify us in restricting the activity in general justify us in doing so through swingeing taxes, in particular.

The problems with the taxation strategy are political, not moral. Through it, we give one powerful bureaucratic actor—the Treasury—a substantial interest in continuingly large volumes of cigarette sales. There is a risk, which has become a reality intermittently from the time of King James I onward (Harrison 1986), of financial considerations dominating health ones in the counsels of state (Breslow 1982, pp. 130–31; Taylor 1985, chap. 8; Wilkinson 1986, chap. 8).

In a way, there is no reason for the Treasury to mind, and much reason for it to welcome, increased tobacco taxes. "As long as the price elasticity is less than one"—and the U.K. Treasury's official estimate, recall, is -0.46 (U.K. Her Majesty's [HM] Treasury 1980, p. 106)—"the revenue will certainly increase when the tax goes up" because "the fall in consumption is more than offset by the extra tax paid by those who continue to smoke" (Atkinson and Townsend 1977, p. 492; see also Townsend 1987, p. 364; and Godfrey and Maynard 1988, p. 342). Thus it is estimated, by H.M. Treasury itself in Britain, that a 10 percent increase in the tobacco tax would yield an extra £ 178 million in net revenue, even after taking into account substitution effects, income effects and other second-round economic effects (U.K. HM Treasury 1980, p. 99).

Of course, that is not quite the whole story. If the effect of the increased tobacco tax is to prevent recruitment of new smokers, the long-term effects might be a reduction in tobacco tax revenues, as existing smokers eventually die off. For that reason, a Treasury operating with a very long-time horizon may oppose increases in the tobacco tax. And, of course, the tax revenues it receives from tobacco

44. The passage continues: "Every increase of cost is a prohibition, to those whose means do not come up to the augmented price; and to those who do, it is a penalty laid on them for gratifying a particular taste. Their choice of pleasures, and their mode of expending their income, after satisfying their legal and moral obligations to the State and to individuals, are their own concern, and must rest with their own judgment" (Mill 1859/1975, p. 123).



would give the Treasury a strong incentive to oppose reductions in tobacco consumption accomplished through any means other than increased tobacco taxes. But, at least when operating on the short-term logic that drives most treasury departments, there is really no good reason why they should oppose increases—even very sharp increases—in tobacco taxes.

I conclude, therefore, that dramatically increased taxation of tobacco might form one useful component in an overall smoking control strategy. It would be particularly useful in preventing the recruitment of new smokers, in their early teens. It would be less useful, however, in causing existing smokers to abandon the practice. For that, something else is probably required.

### 2.4.4 *Publicity*

Mandatory health warnings on cigarette packages and advertisements, and health education and health promotion campaigns more generally, are another popular government response to smoking. Some thirty-eight countries now require printed warnings on packages and advertisements, of one form or another (Roemer 1986, pp. 7–8). And there has been a trend toward requiring stronger and more explicit warnings, in recent years.

Among the more important reasons for the popularity of this strategy is that health warnings and health education campaigns are seen as the least paternalistic forms of government intervention.[45] Mill (1859/1975, p. 118) himself holds that "labelling [a] drug with some word expressive of its dangerous character, may be enforced without violation of liberty," since presumably "the buyer cannot wish not to know that the thing he possesses has poisonous qualities." In this judgment, Mill has been followed by a whole host of more recent commentators.[46]

No doubt publicizing health risks reduces smoking. Publication of the two great official reports—by the Royal College of Physicians in 1962 and the surgeon general in 1964—produced long-term drops in cigarette consumption standardly estimated at 7–14 percent (Atkinson and Skegg 1973; Leventhal and Cleary 1980, p. 381; Warner 1981). The antismoking television advertisements, broadcast under the Fairness Doctrine in the United States until cigarette advertising

45. Some, though, protest the paternalistic bossiness of health education campaigns run by medics in the habit of issuing orders and demanding obedience (Meenan 1976).

46. See, e.g.; Feinberg 1971/1983, p. 11; Wikler 1978/1983, pp. 52–53; Littlechild and Wiseman 1984, p. 66; Buchanan 1970, p. 72; Daniels 1985, p. 158; and Littlechild 1986, pp. 275–76.

itself was banned from television in 1970, seemed to have had an effect almost twice as strong (Hamilton 1972, p. 406).[47]

There are reasons to believe that health campaigns cannot work in isolation from other policy initiatives, though. Specifically, allowing cigarette advertising undercuts health messages by inducing newspapers and magazines to engage in self-censorship of health reports that might offend their tobacco sponsors (Smith 1978; Warner 1985; Warner et al. 1986). Thus, a publicity campaign might not really succeed unless coupled with something stronger: an advertising ban. Otherwise the message simply might not get carried effectively.

### 2.4.5 *Bans*

There are, in fact, various different regulatory options under this general heading. Most modestly, we might ban cigarette advertising, either in particular settings (e.g., on television) or in general. More dramatically, we might ban sales of cigarettes, either to a certain group (e.g., children) or in general. Most dramatically, we might ban use of tobacco, either in particular settings (e.g., where there is a particular fire hazard, as in elevators, theaters, and subways, or where there are synergistic effects with other substances in the immediate vicinity, such as asbestos) or in general.

These are separable policy options, any one of which can be pursued independently of any other. From 1975, Norway has banned advertising but not sale of cigarettes. Similarly, we can ban sale without banning consumption. (Most states allow you to eat game birds and fish you shoot or catch yourself but not to sell them.) Though there is no modern experience of a general ban on sale or use of tobacco, advertising bans are reasonably common: fifteen countries have total bans, and another twelve have strong partial bans (Roemer 1986, pp. 7–8).

Advertising bans can be particularly helpful in reducing cigarette consumption among adolescents, with whom we should be especially concerned on grounds of "informed consent." There is good evidence that cigarette advertising in general, and sport sponsorship in particular, appeals to children (Aitken, Leather and O'Hagan 1985; Aitken et al. 1987; Chapman and Fitzgerald 1982; Ledwith 1984; Warner et al. 1986). Conversely, banning advertising of cigarettes in Norway in

47. Schneider, Klein, and Murphy (1981) argue that models used to generate those results are misspecified; on their revised estimates, the cumulative effects of the 1953 American Cancer Society and 1964 surgeon general reports were to reduce tobacco consumption by 25 percent and antismoking commercials by another 5 percent. Note that their dependent variable—tobacco consumption—can be reduced by shifts to filter cigarettes (as happened especially in the post-1953 period) as well as by reductions in cigarette consumption per se.



1975 led to a sharp decline in the percentage of teenagers who subsequently have become daily smokers (Chapman 1985, pp. 16–18; 1986, pp. 39–40; British Medical Association [BMA] 1986; Warner et al. 1986, p. 372; White 1988, p. 159). Of course, it is perfectly true that tobacco consumption, particularly among the young, might be reduced even more by cleverly crafted antismoking commercials as appeared on television in the United States before 1970 (Hamilton 1972, p. 406; Miller 1985; U.S. CEA 1987, p. 186). But if the products are genuinely dangerous, we could perfectly well run commercials advising against their use without being obliged, in fairness, to allow commercials advocating their use.

Against bans on the use or sale of tobacco, the Prohibition analogy is standardly urged.[48] Already we have evidence of substantial "bootlegging" (or "buttlegging") of cigarettes between states with low cigarette taxes and those with high ones (Manchester 1976; U.S. Advisory Commission on Intergovernmental Relations [ACIR] 1977). Any more serious ban on sale or use of tobacco would no doubt lead to even more illicit activity of this sort. Even accepting such slippage, however, this strategy is still bound to reduce smoking substantially. Whether more would be lost in terms of respect for the law than would be gained in terms of public health remains an open question.

### 2.4.6 *Medicalization*

If nicotine is an addictive substance, as argued in section 2.2.2 above, then perhaps a medical rather than legal or economic response to its consumption, via smoking tobacco, is indicated. The idea here would be to make tobacco a prescription drug, available to registered users only.[49] Methadone maintenance programs for heroin addicts might serve as a model.

48. Mill 1859/1975, pp. 108–10; Schelling 1980, p. 110; Breslow 1982, p. 140; Littlechild and Wiseman 1984, p. 64; Lundberg and Knoll 1986. The analogy has more historical warrant than those employing it realize; see sec. 4.9 below for details.

49. If this seems like a bizarre proposal, it is worth recalling how recent an innovation compulsory drug prescriptions is. "Before 1938, the only drugs for which prescriptions were needed were certain narcotics specified in the Harrison Anti-Narcotics Act of 1914. Any other drug could be obtained by walking into a pharmacy and buying it" (Temin 1979, p. 91). Ironically enough, nicotine-containing chewing gum is in many places—the United States, the United Kingdom, Canada, Sweden—available only on prescription, whereas the most closely analogous tobacco product (the currently favored form of chewing tobacco, "wet snuff") is freely available over the counter to adult purchasers, although its nicotine content per "dose" is twice as great (Koziowski et al. 1982). Perhaps as a first step in the "medicalization" direction I am here considering, Czechoslovakia now requires consumers of twenty or more cigarettes per day to register with the medical service that monitors respiratory diseases there (*Daily Express*, London [February 17, 1986]).

The aim in making tobacco a prescription drug would be to respond humanely to the needs of present addicts, while discouraging new users. Again, it would be impossible to stop all new users. They can always smoke the cigarettes of registered users illicitly (unless, following the methadone-maintenance model, we require registered users to smoke only in the clinics). But, again, such a policy would have a strong tendency in the desired direction.[50]

### 2.4.7 *A Composite Policy Package for Smoking Control*

Reflecting just upon the harm that smokers do to themselves, in light of various moral doctrines, led us to set as our policy goal the curtailment of smoking as such. Making tobacco a prescription drug is clearly the most appropriate method of doing so, given the way in which I argued for that goal in the first place. The reason that people cannot meaningfully consent to the risks of smoking is that they are addicted; and the way we cope with addictive drugs is to put them on prescription. The only reason, utilitarian or otherwise, for allowing smoking to continue at all is out of compassion for existing addicts; putting tobacco on prescription would get it into their hands but (virtually) no others.

That is a novel proposal, however. I have few illusions about its practical political prospects, at least in the short term. As a second-best stopgap, I therefore propose a package of more familiar policy options. It would start with more serious enforcement of laws already on the books against selling cigarettes to minors or (what typically amounts to the same thing) breaking packs and selling single cigarettes. The centerpiece of my reform proposals would be a swingeing tax on tobacco products—again designed primarily to stop people in their early teens from starting to smoke in the first place. That would be combined with a stringent ban on tobacco advertising in all its forms (especially sponsorship of sporting, cultural, and other events that tends to make smoking attractive in the eyes of youngsters, again).[51] With those policies in place, health education campaigns—particularly antismoking advertisements of the pre-1970 form—could then serve as useful supplements to discourage smoking. That package is not ideal, leaving many existing addicts without any very strong inducement to stop. Still, it may be the best that, politically, we can do.

50. Peltzman (1987), using admittedly thin data, finds that making certain medicines available by prescription only has not had the desired effects of reducing overdoses or suicides using them. More worryingly for the tobacco application, he finds that putting drugs on prescription actually increases demand for them. But presumably the reason is one that has no analogue in the tobacco case: putting a therapeutic drug on prescription constitutes a guarantee of its usefulness in curing disease.

51. This combines with a ban on smoking in public, justified in sec. 3.5.5 below in terms of harms to others.

# 3 Harm to Others

If protecting smokers from harms that they do to themselves when smoking is the most obvious reason for restricting smoking, protecting nonsmokers from harms that they suffer at the hands of smokers has proven politically the most compelling in contemporary debates. This chapter opens with a brief statement of what is known about the extent of those risks (Sec. 3.1).

Whether those risks can ground ethical justifications for restrictions on smoking in public is the subject of subsequent sections. Some arguments juxtapose a putative "right to smoke" with the right to breathe clean air (Sec. 3.2), while others turn on the alleged voluntariness of passive smoking (Sec. 3.3) or the alleged disutility of preventing it (Sec. 3.4).

The upshot of all of those discussions is that the risk of damage to others from a person's smoking nearby is a real one, and in light of it we should strive to restrict smoking in public places. The closing section (3.5) surveys various policy options for promoting that goal. These range from self-restraint on the part of smokers, through reliance on market forces, to legislation banning or restricting smoking in public places. In the end, I conclude that the latter, more stringent measures will necessarily have a large role to play in any overall program to stop passive smoking.

## 3.1 THE NATURE OF THE RISKS

Broadly speaking, there are three classes of negative effects on others arising from a person's smoking nearby. The first two—harm to the fetus and harm to passive smokers—clearly are harms. The third—creation of offensive odors—is the first cousin of a "harm," if not exactly a harm in the classic sense.