Smoking Policy: Law, Politics, and Culture

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Comparing Cigarette Policy and Illicit Drug and Alcohol Control

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Tobacco is not the only habit-forming psychoactive substance that is regarded as a special problem for public policy in modern American life. Alcohol, prescription drugs, and a variety of currently illicit substances, including marijuana, heroin, and cocaine, are judged to pose significant challenges to public health and public order, and these substances are associated with a variety of public law strategies to minimize the damage they inflict.

The variety of substances and the range of regulatory strategies associated with them invite comparative study. While the various components of modern society's psychoactive cornucopia differ from each other in important ways, the lessons we learn in regulating one substance should prove helpful in assessing the costs and benefits of strategies to regulate others. The question of the moment is, what insight into the social and governmental dynamics of cigarette regulation can be gained from comparing public policy toward cigarettes with policy toward drugs and alcohol?

The first section of the chapter discusses three respects in which patterns of drug, alcohol, and cigarette use have been parallel despite contrasting legal regimes. I argue that, rather than changes in legal regulation causing changes in levels of substance use, often it is the other way around. Socially caused decreases in drug and tobacco use, particularly those that remove large numbers of high-status users, prepare the way for the adoption of get-tough programs by government.

The second section of the chapter examines the distinction between the general criminal prohibition of some drugs and the kind of regulation without prohibition that currently governs alcohol and tobacco. What is thought to be the distinctive attribute of criminal prohibition is the capacity to convey stigma, yet not all criminal prohibitions generate strong social stigma and some forms of noncriminal government policy may still convey disapproval effectively.

This leads to the final section of the chapter, where I suggest that the late twentieth-century tobacco policy seems increasingly like a stringent but nonprohibitionist policy that facilitates, if it does not cause, a substantial level of social stigma against cigarette smoking. If this combination works well with cigarettes, it might become a model for control of other substances.

Three Parallels

The most significant lesson in the recent history of drinking, drug taking, and smoking concerns the variability in use rates arising from social change. Recognizing how much variations in behavior originate in social changes helps us guard against assuming that any changes in smoking rates that occur after government action were caused by that action. Three parallel patterns in the social history of cigarettes and of other drugs merit special attention from students of public policy: (a) the degree to which smoking and drug-taking behaviors change over time as a result of nongovernmental processes; (b) the "trickle-down" pattern of desistance that has characterized both cigarette smoking and cocaine use in recent years; and (c) the extent to which shifts in public policy have often resulted from socially motivated desistance from cigarettes and drugs rather than causing them. When social support for a substance drops off, and when smaller proportions of the middle class use the substance in question, the conditions become more favorable for stringent governmental controls in a democracy. This pattern can be observed in the history of a variety of substances.

Desistance as Social Change

With respect to alcohol, per capita consumption in the United States varied by a factor of three and one-half over the nineteenth century and has varied by a factor of two over the twentieth century (Lender and Martin 1987). The use of other drugs has probably fluctuated even more than has alcohol use, which has a settled institutional base that contributes to lower volatility.

One of the principal lessons from the period before the first alcohol prohibition periods in the 1850s is that wide fluctuations in alcohol use occurred independently of legislative or law enforcement action. Nationally, per capita consumption of alcohol is reported to have dropped by 70 percent in the thirty years before the first state-level prohibition statute. Thus, it should not be assumed that any change in the folkways of drug use must be attributed to some prior shift in "stateways."

This appears true for illicit drug use as well as alcohol. Although we are only beginning to use multiple measures to assess shifts in the consumption of a wide variety of drugs, including marijuana, cocaine, and amphetamines, what we have learned to date about the consumption patterns of those drugs is consistent with the historical data on alcohol consumption. The use of particular illicit drugs often follows cyclical patterns, where upward and downward shifts in the incidence of use occur that are not related to changes in government policy (see Zimring and Hawkins 1992, pp. 74–75).

Patterns of cigarette consumption have also varied substantially with changing social conditions. The twentieth century has witnessed a huge upswing in tobacco consumption that was a product of social and marketing shifts, an increase that occurred in different eras and with different intensities for men and women. But in the past two decades, the United States has experienced a decreasing prevalence in cigarette smoking, resulting from individual and group reactions to cigarettes and health.

There is no disputing that the tremendous upsurge in smoking in the first half of

the twentieth century was a social phenomenon. But some observers may be tempted to assume a cause-and-effect relationship between government antismoking measures over the past two decades and the decline in smoking prevalence. Yet the broad international character of the decline and the temporal sequence of both the trends in smoking and most government countermeasures suggest that social change is the major explanation of changes to date in cigarette smoking in the United States.

The Multinational Pattern. The downward trend in smoking extends well beyond the borders of the United States, and the international breadth of the pattern is further evidence against assuming that the decreasing prevalence of cigarette consumption is mainly a function of the acts of particular governments at specific times. Since mid-century, information on the health dangers of cigarettes has been disseminated and digested in social systems all over the industrial world. It is likely that this change in perceptions about cigarettes is most responsible for the broad pattern of desistance.

Figure 5.1 is reproduced from a World Health Organization report and gives trends in the prevalence of cigarette smoking by males for the period from 1970 through 1985.

The pattern of decline documented in this figure extends across the majority of western industrial countries and is similar in timing, if not in magnitude. No national government can be the principal architect of this broad temporal trend.

The most plausible explanation for a broad multinational trend of the magnitude and character of figure 5.1 is the adjustment of social attitudes and systems to definite information on the health risk posed by smoking. Widespread discussion of smoking risks begins after 1950 and receives particular focus after the 1964 Surgeon General's report. This new information begins to have noticeable impact on individual perceptions and social attitudes in the late 1960s. As individuals modify their behaviors, the conditions for social change can occur with little or no further government intervention. The broader the transnational change, the more likely that voluntary adjustments to new information is a major explanation for the shift.

Yet observing a trend over time in only one jurisdiction without knowledge of the breadth of the downturn could invite the conclusion that particular actions of government in the jurisdiction under study were responsible for more of the observed change than was in fact the case. So figure 5.1 serves notice both of the value of comparative study when trend over time is a significant issue and of the dangers of attributing shifts over time to policy changes in particular jurisdictions.

The Trickle-Down Pattern of Behavior Change. The decline in the social status of smoking in the United States involves more than just the number of persons who have quit smoking. There is a qualitative dimension to the decreasing prevalence of smoking that explains why smoking and smokers have lost status so quickly in American society. The first generation of those who quit smoking cigarettes was made up of disproportionate numbers of high-status persons, and the leadership of these persons makes a special contribution to the erosion of popular sympathy for smoking and smokers (Pierce 1991).

I will call this pattern of desistance a "trickle-down" process, because older and higher status groups are trendsetters. The move away from smoking thus started at

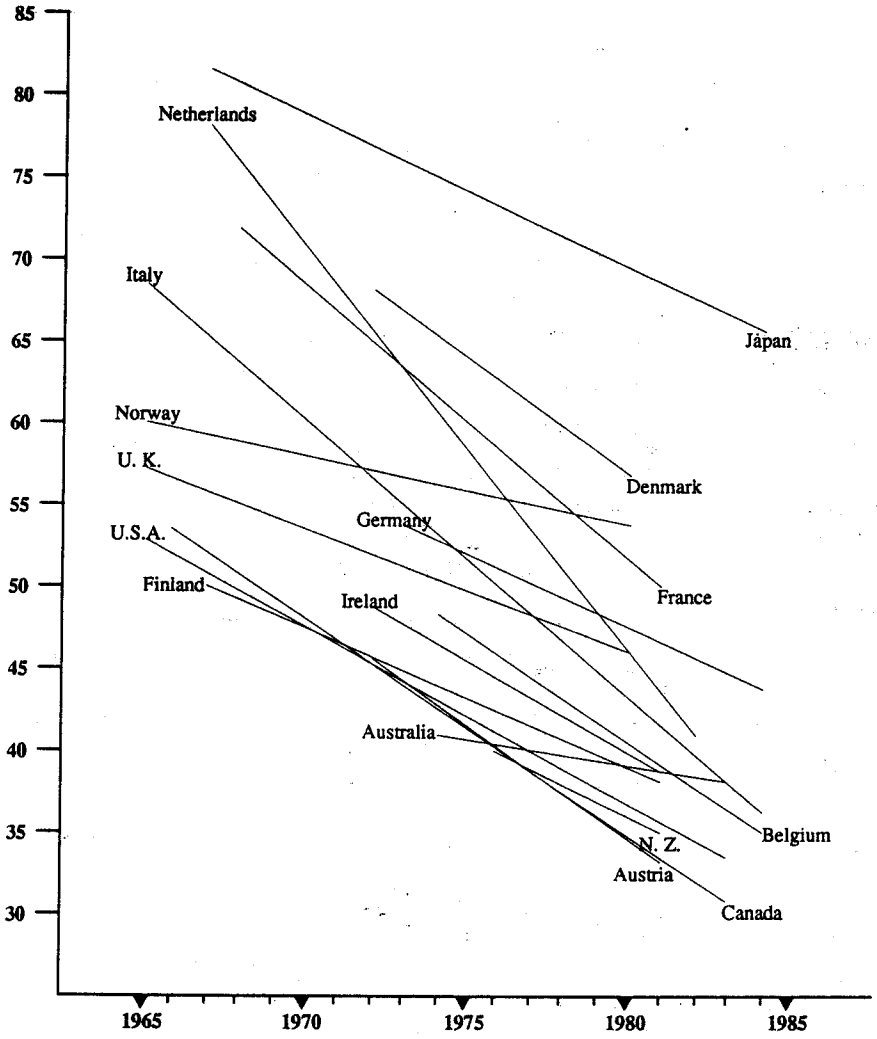

Figure 5.1. Trends in Smoking Prevalence by Men. Source: Reproduced, by permission, from Marsh, The Dying of the Light: Why People Smoked and Why They are Stopping (Smoke-free Europa Series No. 7). Copenhagen, WHO Regional Office for Europe, 1987.

the top of the social distribution in the 1960s and 1970s while lower-status segments of the population lagged behind. "One hundred thousand doctors have quit smoking" was an advertising slogan in the anticigarette campaign long before similarly significant proportions of young persons had quit. Just as trickle-down economic theories hope that the economic lot of the poor will improve after the well-off gain more wealth, it is hoped that the behavior of high-status groups will be later reflected across class, age, and ethnic categories.

The sharp trickle-down pattern present in the declining prevalence of smoking in the United States is consistent with the conclusion that the decline is in response to

health information. That is, because the middle-class and middle-aged are more likely to respond to health appeals than younger and lower-status groups, the social shape of the trend toward desistance lends credibility to the theory that this social change is largely information-based.

A parallel example of a trickle-down pattern was observed in the 1980s with respect to cocaine use. Cocaine began that decade with a reputation as a relatively benign illegal drug, one possessing a user population that contained relatively high proportions of high-status and high-income adults, at least when the cocaine-using population was compared with user populations of some other illegal drugs. But the older and higher-status users fell away quickly in the 1980s as the anticocaine campaigns heated up in the United States and the social reputation of cocaine declined. By 1988 cocaine use was said to be concentrated among young, low-status, and minority populations, by then consisting increasingly of persons smoking crack (Roehrich and Gold 1988).

The qualitative shift in user populations that characterizes a trickle-down pattern helps to explain how the social status of a substance can decline more rapidly than the proportion of the population using it. When the residual population of users is disproportionately low-status, young, or marginal in other respects, desistance patterns that reduce the population of users by only 30 or 40 percent can still be associated with sharp declines in the social status of use. Whether the trickle-down pattern is only a symptom of declining social reputation (and that is why high-status individuals abandon use) or whether the qualitative shift in who is using a substance can independently influence the social reputation of substance use for others in society is hard to say on present evidence. My guess is that both influences are at work in the recent change in cigarette smoking.

In either case, however, a trickle-down pattern of desistance invites the attachment of moral stigma to the residue of the population that continues to use a substance. I shall argue later that there is a current shift toward perceiving cigarette smokers as morally blameworthy individuals. If this is so, it would be much more difficult to imagine such a stigmatization if the legendary 100,000 doctors (and millions of other agents of social leadership) had not been disproportionately represented in the vanguard of former smokers created in the United States during the 1970s and 1980s.

The Social Causes of Policy Shifts

Students of the social impact of legislation tend to focus on changes in law as a cause of changes in behavior. Yet it may also be important to study the extent to which changes in social behavior create a climate in which legal change can take place. A decline in the number of persons using a substance narrows the support for the use of that substance among the general public, and the trickle-down pattern in which high-status persons differentially decrease use may narrow the base of support for a substance more quickly than a decline in use that is evenly spread across social classes. In our drug policy study, Gordon Hawkins and I found that not infrequently in U.S. history declines in the use of drugs and alcohol helped to create

a climate favorable to the passage of restrictive laws (Zimring and Hawkins 1992, Ch. 3). This seems the pattern as well with cigarette smoking in the 1970s and 1980s.

Both episodes of alcohol prohibition in the United States occurred after periods of decline in per capita consumption of alcohol. While less is known about the extent of opiate and cocaine consumption on the eve of World War I, it appears to have been neither particularly widespread nor sharply on the increase. Indeed, it is notable that there has never been sharply increased use of a psychoactive drug among broad segments of the population as a precursor to prohibition. Instead, declining use and restrictive laws are often both symptoms of the lower social status of particular drugs, and declining use often precedes official public acts restricting drug use.

The sequence of events in the recent public policy career of tobacco is typical of the general pattern. The official antismoking campaign was confined to exhortation and information for over a decade before strong pressures to eliminate cigarette smoke from work areas, public places, and airplanes produced negative zoning legislation in the late 1970s and 1980s. Measured as a percentage of the total adult population, the share of smokers had declined for at least a decade by the time the zoned prohibitions became popular, and the social status of smokers had also declined. Thus, while governmental persuasion in the form of the 1964 Surgeon General's report no doubt helped launch the social shift away from smoking, most of the coercive governmental action came well after the downward trend had started. The regulatory bite of government smoking policy in the United States happened well after the desistance pattern had become pronounced.

I am not arguing that the only plausible causal sequence is declining use, yielding lower social status, leading to restrictive legislation. Rather, my position is that the relationship between declining use and restrictive laws over time is a complicated two-way street in which governmental initiatives may both be caused by and cause declines in use. Frequently, however, the complexity of this relationship is missed when observers speak of the trade-off between various different regimes of regulation and their public health impacts.

It has been said, for instance, that criminal prohibition of substances produces much lower use rates than do legal regimes that regulate but do not prohibit. But if regimes of prohibition are usually initiated and maintained only under conditions of low social usage, it is highly misleading to compare the two strategies in terms of the use rates associated with them. In other words, a large part of the difference in usage that we find associated with prohibited drugs is the condition that made the prohibition possible rather than the result of the legal status. Crediting the criminal law for the low usage levels of prohibited substances is a bit like congratulating children for the fine job they did of raising their parents.

Prohibition Versus Regulation

The basic contrast between government response to tobacco and to illicit drugs is the obvious point that the use of tobacco is not prohibited to all citizens by the

criminal law while illicit drugs are the subject of a general criminal prohibition. Comparing the way tobacco and illicit drug policies are carried out helps to define the real-world differences that prohibition and regulation produce. This section first discusses the complex of choices that lie behind the labels of prohibition and regulation for psychoactive substances, a choice between giving the criminal law total control of substance regulation and using the criminal law as a backup to other forms of primary regulation. That is followed by a discussion of the relationship between the type of government regulation used for a substance and the moral view about the substance on the part of citizens. While the principal advantage of a general criminal prohibition is that it facilitates the attachments of moral stigma to behavior, the recent history of tobacco use suggests that this can happen without general prohibition as well.

Contrasting Mechanisms

There are two distinct ways one can ask about the difference between prohibition and regulation as a governmental strategy:

1. What difference does the criminal law make in state regulation of psychoactive substances?
2. What are the characteristic elements of state regulation of psychoactive substances when the government does not seek to prohibit substance use by citizens?

The first question emphasizes the distinctive elements of the criminal law and the criminal process. This is the conventional way in which scholars, particularly legal academics, have structured comparisons of criminal and noncriminal regulatory processes. Further, the distinctive processes of the criminal law have preoccupied comparative discussion of regulatory options for drugs (see Nadelmann 1989; Packer 1968).

If the question is asked in the second way, the emphasis shifts from centering attention on the criminal process to examining the wide variety of elements of governmental efforts to limit and channel uses of psychoactive substances short of general prohibition. In the 1990s, a strong argument can be made for the value of the second phrasing of the question. The last half century has seen a substantial increase in the instances where the government has an interest in limiting or discouraging behaviors or substances for public health and safety reasons, but pursues these ends through policies other than criminal prohibition.

Indeed, most psychoactive substances susceptible to abuse are governed by methods other than general prohibition, such as regulatory schemes that attempt to control the time, place, manner, and extent to which substances can be ingested. Furthermore, government policy seeks to either discourage or restrictively regulate not only alcohol and tobacco, but substances ranging from dietary fat to prescription tranquilizers (see, e.g., Code of Federal Regulations 21: 70–800). Thus, the distinctive institutional patterns and tensions associated with regimes of regulation without prohibition raise questions that are both theoretically interesting and practically important in modern societies, where increasing numbers of behaviors and sub-

stances are seen to affect the public welfare but where the use of general prohibition is restricted to a few consensus public harms.

Of course, it is far from the case that alcohol and tobacco are unregulated by the criminal law. There are more laws—including more criminal laws—regulating tobacco and alcohol than there are laws concerning most substances covered by general criminal prohibitions. Criminal laws prohibit selling and distributing tobacco to minors, smoking in designated places, and many other aspects of cigarette use (see, e.g., California Penal Code Section 308 [sales to minors]). And alcohol has spawned its own distinct criminal jurisprudence as well as manifold laws regarding its use, sale, and effects (see, e.g., California Business and Professions Code Sections 23000–25762). Yet while a great number of criminal laws support the regulation of alcohol and tobacco, this sort of regulatory enforcement has a low priority in general jurisdiction policing, and law enforcement perspectives are less dominant in the construction of policy for regulated substances than is the case for prohibited substances.

The contrast between regulation and criminal prohibition concerns not just the kind of policy that is made, but the people and the institutions that make policy. For prohibited substances, law enforcement is the dominant expertise consulted in the policy process. The great majority of governmental experts on heroin and cocaine are police officials (see, e.g., Select Committee on Narcotics Abuse and Control 1990b [seven of eight professionals on the witness list from law enforcement], 1987 [six of seven witnesses with professional backgrounds from law enforcement], and 1990a [seven of eleven witnesses from law enforcement]). The range of disciplines and locations of government responsibility that have influenced policy toward tobacco, alcohol, and prescription drugs are much larger. While medicine and public health are consulted to some extent in policy toward prohibited substances, the influence of these disciplines on policy seems much larger for regulated substances, and their influence extends well beyond medicinal claims and applications (see, e.g., U.S. DHHS 1980a, pp. xiii–xxii).

The dominance of law enforcement with respect to prohibited drugs extends well beyond the boundaries where the comparative advantage of police would follow logically from the status of the substances prohibited. Law enforcement personnel are considered authorities not only on methods of interdiction and apprehension but also on patterns of prohibited drug use, drug effects, and other matters that are not closely connected to police training and expertise. Police are also regarded as experts on illicit drug prevention and education programs. It is as if the classification of behavior as criminal provides police with a special province for understanding every aspect of that behavior. In fact, criminal prohibition does make access to information about the use of prohibited drugs harder for public health, education, and welfare professionals to obtain. Still, it is by no means clear that the comparative advantage in relation to illegal substances lies with police authority on questions that range from pharmacology to pedagogy.

Enforcement of criminal law seems always to be a higher priority for law enforcement if a substance is subject to a general prohibition rather than only regulated as to the time, place, and extent of use. The operative distinction is

probably that general prohibitions are easier to imagine as clear-cut conflicts between good and evil. Whatever the reason, however, it understates matters to say that searching for the French Connection constitutes a higher priority for police agencies than enforcing the criminal prohibition against serving liquor to minors or ensuring compliance with regulations governing prescription medicines. Absent the creation of special-purpose law-enforcement agencies that are devoted to supporting regulation of licit drugs, the enforcement of regulatory support functions for licit substances can drift very close to the absolute lowest priority for general jurisdiction police (see Wilson 1968, pp. 118–21). Thus, it should come as no surprise that general jurisdiction police place very low priority on both the enforcement of tax laws in relation to cigarettes and the enforcement of age-specific prohibitions. The same is true for juvenile and criminal courts. Indeed, no police agency at any level of government gives policy attention or priority to criminal laws regarding sale or access to cigarettes.

Just as the institutions and styles of enforcement vary for regulated and prohibited substances, there is substantial variation in the structure and intensity of law enforcement activity for different regulated substances. As an aftermath to Prohibition and its repeal, those who play key roles in the regulation of alcohol are special-purpose personnel who are very close to and identify with the alcoholic beverage industry. Tax and production control authorities are close to the producers of alcohol and identify with that segment of the industry. State and local beverage control authorities also tend to identify positively with the legitimate production and distribution segments of the industry (see Zimring 1975).

The tobacco story is more complex. Policy has been made in different branches and levels of government by a variety of different policy communities. In state and local government, there is no natural center for policy analysis of cigarette policy. At the federal level, tobacco's constituency in the Department of Agriculture has less in common with tobacco policy groups in the Surgeon General's office than it does with other special-purpose constituencies in the Department of Agriculture. And the public health groups that have been increasingly influential on federal policy statements toward tobacco do not seem to have been closely connected with any regulatory agencies other than the Surgeon General's office.

For some time then, tobacco policy has primarily been discussed at a federal level, where the policy community has been abstracted from both commerce in cigarettes and criminal law enforcement. Coordinating the design, enforcement, and evaluation of legal controls on cigarettes has been almost literally nobody's business in the patchwork of federal, state, and local responsibilities that has evolved. This lack of policy planning may not be destructive where regulations about smoking are costless and self-executing (see Kagan and Skolnick, this volume), but the usual results of anarchy in the policy planning process are lack of focus and priority.

A further contrast between government campaigns to regulate and to prohibit substances relates to the prominence of persuasive appeals in the total government effort. When mind-altering chemicals are not illegal, persuasion campaigns in the general media and in school settings are frequently used as high-priority elements in

efforts to moderate abuse. For a quarter-century, the quit-smoking campaigns have been emulated by antialcohol and antidrunk-driving persuasive messages, created with governmental participation and approval.

Persuasion aimed at users and potential users was for a long time less frequently and less prominently used in governmental campaigns against illegal substances. Perhaps persuasive messages to illegal drug users were believed to confer too much autonomy on the user. Or perhaps persuasive appeals were considered necessary for the licit drug campaigns, but inferior to punishment threats when dealing with illegal substances.

However, apparently inspired by the anticigarette appeals to adolescents and adults of the 1970s and 1980s (see Polich et al. 1984), this reluctance has been overcome. At least since the mid-1980s, publicly sponsored and encouraged illicit drug control campaigns have been designed for general media programming to adult audiences and school and mass-media prevention programs aimed at the young (see Levine 1991). Whether or not the anticigarette campaigns were regarded as successful by tobacco policy insiders, they seem to have produced a rare instance of technology transfer in substance policy from cigarettes to drugs.

The Moral Dimension of Policy Alternatives

Whatever the problems with criminal law controls, the advantage of general prohibition is moral simplicity. The message the government transmits is that the use of the substance is wrong and the people who use it are bad. Whatever the gaps between the message sent and the message received by many different social audiences, the moral force of criminal prohibition is not hampered by internal inconsistencies.

Regulation of substances that falls short of criminal prohibition frequently sends mixed messages that might compromise government's ability to condemn substance use and to morally isolate those who violate regulatory prohibitions concerning a substance. The government has said that all use of heroin by all persons is a serious offense. And it is hard for individuals who contemplate the use of heroin to imagine that government policies see them as anything less than moral miscreants. They may not care much, but they know.

The moral message of nonprohibition policies is less clear. Cigarette smokers who are under eighteen may knowingly violate the law, but it is easy for them to reason that state policy does not see them as engaging in morally offensive behavior. How can one characterize those under eighteen who smoke as immoral when the government taxes rather than condemns the same behavior by an adult? The law may wish to brand the underage smoker as immature, but smoking itself is sufficiently sanctioned for fifty million American adults that the government's attempt to define the behavior by young smokers as morally offensive is substantially undermined.

The circumstances surrounding the moral status of those adults who supply cigarettes to young smokers is a more complicated matter, but the messages provided by regulatory enforcement allow enough room for confusion to mitigate the moral harm of this offense. Adults supplying cigarettes to minors are engaging in

predatory behavior, exploiting the immaturity of their customers for personal gain. Under these circumstances, determined state enforcement machinery could probably push for penalties attached to such behavior that were substantial if still short of jailing.

But even this is far short of the moral fury the public attaches to the people who sell illicit drugs to children, where it is hard to think of criminal punishments that are not regarded as too good for the guilty. The similarity of these two cases is the corruption of minors, but the social meaning of the substances is quite different because the state does not condemn the use of tobacco by adults. This limits the moral condemnation even of those who corrupt the young by moderating the negative image of the substance that is the source of corruption.

The contrasting moral accounts of heroin and cigarette smoking would have served as textbook examples of the difference in stigma between licit and illicit drugs until quite recently. Heroin was projected as antisocial as well as self-destructive in all public depictions of its use. The cigarette smoker, by contrast, was regarded as victim rather than offender in the anticigarette propaganda of the 1960s and 1970s in the United States. Youthful foolishness was as close to sin as these portrayals would come in relation to the smoker, while the moral fury of the antismoking crusaders was reserved for tobacco companies. These corporate entities, treated much as the armament manufacturers who were labeled as "merchants of death" in earlier days, were the only embodiment of evil in the private-sector antismoking crusades (see Whiteside 1971). And government campaigns proceeded for two decades without any moral villain. But all of this may be changing in ways that may instruct us in the possibility of stigma without criminal prohibition. This important possibility is discussed in the next section.

The existence of large categories of nonprohibited use is conventionally thought to undermine the moral force behind criminal law regulation of the use of mind-altering substances. The limited capacity to condemn and stigmatize the use of drugs permitted by law suggests the slogan, "It is impossible to prohibit what you regulate." This is a corollary, if you like, to the slogan, "It is impossible to regulate behavior that is prohibited" coined by my colleagues Norval Morris and Gordon Hawkins concerning the regulatory inflexibility of criminal prohibitions (Morris and Hawkins 1977, p. 21).

However, general laws about the moral messages of prohibitory and regulatory regimes are not easy to derive from historical experience. It has long been suspected that criminal prohibition is not a sufficient condition for stigma to result. That was demonstrated by the moral career of alcohol prohibition from 1919 to 1933. Even longer-term prohibitions are not inevitably bulwarks against the social acceptance of particular forms of drug use, as shown by the growth of a relatively benign reputation for marijuana in some parts of the United States in the 1960s and 1970s after thirty years of criminal prohibition (Zimring and Hawkins 1992, Ch. 3). So identifying the criminal prohibition as less than a sufficient cause for moral stigma is not controversial.

There is more novelty in the suggestion that criminal law may not be the only means of government policy capable of conveying and reinforcing stigma. While there are limits to the government's capacity to stigmatize short of prohibition, a

mix of social attitudes and noncriminal governmental regulations may produce substantial changes in the social reputation of a drug, changes that both promote desistance and prevent the onset of drug-taking behavior on the part of socialized groups. Indeed, one way of reconceptualizing the last twenty years' experience of social attitudes and government policy toward cigarette smoking is as a case study on the development of stigma without criminal prohibition. This thesis is argued in the next section.

The Moral Transformation of Smoking

For some years now, we have been witnessing what amounts to a social transformation of cigarette smoking in modern American life, a process in which the image of the cigarette smoker is changing from that of victim to that of one who offends against the interests of innocent persons. The most significant shift in social attitudes toward smoking in the United States in the 1980s and 1990s is the developing tendency in many segments of public opinion and government to view cigarette smoking as socially deviant and morally wrong. If social stigma can be maintained with policies other than general prohibition, it may significantly expand the options that many citizens are willing to entertain for control of other drugs.

The antismoking campaigns in the United States in the fifteen or so years after 1964 portrayed the cigarette smoker as self-harming, either an innocent or a foolish victim of tobacco's ill effects but clearly the primary victim of a tobacco habit. As previously mentioned, to the extent that private antismoking crusades required villains during this period, the black hats were almost exclusively worn by tobacco companies.

Three related developments have altered the portrait of cigarette smoker as victim. First, declines in smoking behavior have made smokers and smoking more vulnerable to negative social evaluations. In many middle- and upper-middle-class gatherings of the 1990s, cigarette smoking is already a socially deviant act. As smokers, the group most interested in defending the moral position of the cigarette smoker, become both less numerous and less influential, smoking behavior and the people who engage in it become more vulnerable to social reinterpretation.

Probably related to the declining social influence of cigarette smokers is the fact that nonsmokers who object to or feel themselves harmed by smoking began to organize and publicize complaints about smoking as a harm to others. The phenomenon of nonsmokers' rights is more significant than the limited numbers in such interest groups might suggest, because the existence of these groups is a symptom of the increased vulnerability of smokers and because the antismoking information and appeals generated by these groups can have a significant impact on the attitudes of many citizens not directly involved in such activities.

A third force behind the shift in emphasis from self-harm to harm to others has been the reorientation in both the patterns of investigation and the patterns of emphasis among the scientists who do research on the health effects of smoking and interpret such research to policy bodies. During the 1980s, the scientific community paid much more attention to morbidity and mortality among a diverse assortment of

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nonsmokers exposed to smoking, including children of smoking parents, nonsmoking spouses, nonsmoking airline passengers and flight personnel, and nonsmoking office workers. The number of articles dealing with the impact of "passive smoking" on health started as a trickle in the late 1970s and soared from 28 studies in 1981 to 213 in 1989 (National Library of Medicine 1975–1991). That the National Library of Medicine in 1982 created the separate category "Tobacco Smoke Pollution" in which to compile passive smoking studies in its *Index Medicus* is further evidence of the increased attention and importance ascribed to these studies. Second-party harms were the focus of the new research in the late 1980s just as certainly as the risks run by smokers was a central concern of the 1960s and the 1970s. The shift in emphasis is dramatic when the Surgeon General's Report of 1986 is compared with the 1964 original (U.S. DHEW 1964a; U.S. DHHS, Surgeon General 1986).

The causal sequence involved in the processes of social transformation is not easy to specify. Each of the three factors mentioned is a plausible candidate as both an outcome of and a cause contributing to the other two features. A decreasing base of smokers can be a result of medical information focusing on smoking harms and of increased agitation by nonsmoking groups. But this shrinking base of smoking behavior can also embolden nonsmokers and leave the individual cigarette smoker as a more identifiable target for nonsmokers' ire. In a room where seven people are smoking, no one of them easily becomes a target for particular blame. When all tobacco clouds in that room are traceable to one or two participants, the finger of blame is more easily pointed.

A similar ambiguity exists about the role of the new scientific concern about passive smoking as both a cause and a consequence of the moral transformation process. A rationalist account would emphasize the new scientific data and concern as a cause of the reorientation. Once some scientists estimate that upwards of sixty thousand nonsmokers are killed each year as a consequence of the smoking behavior of others (see Kleiman 1992), the moral focus of attitudes toward smoking will of course shift from an emphasis on self-harm to the risk of harm to others. But it is equally plausible to see this new focus as a consequence of the concern about smoking as a threatening behavior rather than a cause of the reorientation.

American history has been a repeated witness to dramatic changes in the social reputation of psychoactive substances that were not importantly related to new medical or scientific evidence. The progress of marijuana from the villain of *Reefer Madness* of the 1930s to the harmless universal solvent of early 1970s youth culture is one example. The benign health reputation of cocaine in the 1970s followed by its emergence as a killer drug in the 1980s is a second example (Zimring and Hawkins 1992, Ch. 3).

The first shift during the 1960s in the U.S. policy toward cigarettes is the clear exception to this usual pattern. The Surgeon General's report of 1964 was both prompted by and predominantly influenced by medical research on cigarettes and lung cancer. Most of the social change since 1964 can legitimately be regarded as the progeny of that scientific research and the information campaigns that resulted from the findings of that research.

In timing, at least, the new emphasis in medical research and policy literature on

passive smoking appears to be as much an effect of shifting attitudes toward smoking as a cause (see Garfinkel 1981; Gilles et al. 1984; Akiba et al. 1986). The credibility of these estimates among policy audiences and the immediate use of passive smoking harm estimates in legislative proposals and rule-making probably owe much to the decline in smoking that preceded the arrival of these data and the increase in antismoking concern and activism. By the time the passive-smoking research of the late 1980s was made public, a ready-made market was waiting to receive the news; no parallel market existed for the news in the Surgeon General's 1964 report.

There are two plausible ways to interpret the coincidence of the passive-smoking research and the social conditions to support it in the late 1980s. One is that the appetite for policy applications that portray smokers as dangerous created an overly enthusiastic reception for data implicating passive smoking in the 1980s—parallel to the inappropriately broad embrace of "crack baby" scare stories during that period (see, e.g., Barol 1986). Equally plausible is that the passive-smoking harm hypotheses were stifled due to a lack of funding in the scientific and policy communities until the 1980s. In this telling, the role of the social change in attitudes toward smoking was to finally provide a level playing field in which the merits of the theory could be demonstrated.

Which of these stories comes closer to truth may not be known for many years. Both of these accounts, however, recognize the important influence of social forces on the kind of research conducted and the policy changes that are announced in the name of research. In this sense, very few would assert that the change in smoking attitudes and the shift in focus of the medical research of the 1980s were purely coincidental.

Where will the social transformation of smoking lead the United States in the 1990s and beyond? There are no indications of a smoking renaissance in the United States or anywhere else in the industrial West. The progressive social processes that have been isolating smokers do not seem cyclical; a resurgence in smoking resulting from a change of fashion now seems highly unlikely because of the harms risked by smokers. Unless a socially credible version of a safe cigarette appears, the social consensus around the risks of smoking does not seem imperiled by cyclical patterns.

But legal policy will most probably stop well short of making adult cigarette smoking into a criminal offense. There is some parallel between the growing antismoking fervor and the drive toward alcohol prohibition, but there are differences as well. In the temperance rhetoric that is the backdrop to drug and alcohol prohibition (see Wilson 1990), the intoxication of drinkers and drug takers is itself a threat to morality and productivity. By contrast, smoking itself does not threaten the social order in the world view of most citizens. The moral fault of cigarette smokers is limited in the antismoking account to the harm their smoke does to others. This means that legislation that protects only nonsmokers is a viable alterative to prohibition.

A second difference between the drive to alcohol prohibition and the current antismoking campaigns is the enduring lesson of the prohibition experiment. The consensus that Prohibition failed seems a strong bulwark against attempts to legislate out of existence a bad habit maintained by fifty million adults, or twenty-five

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million, or even ten million. Much stronger prohibitions for the underage, differential health insurance and life insurance rates for smokers, and legal recognition of employer antismoking sanctions are likely in the coming years. Intensified propaganda wars and tax rates that will seem prohibitive to smokers are almost guaranteed. But more than lip service will be paid to adult liberty in this version of the coming decades.

So the midterm policy future for cigarettes will probably be one that builds on and attempts to reinforce stigma but stops short of criminal prohibition for adults. This same pattern has evolved de jure in regulation of pornography in public and de facto for gambling and many other vice behaviors. Given the enormous health costs of cigarette smoking, the pace at which smoking consumption will decline will seem painfully slow. But an almost smoke-free country will be an even more remarkable achievement if its evolution takes place in an atmosphere of government restraint.