

Chapter 2

A Historical Review of Efforts to Reduce Smoking in the United States

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Introduction

Like many other social phenomena, the use of tobacco has created a tapestry of themes, motivations, and social forces, woven together with a complexity that has begun to capture the interest of social historians (Brandt 1990; Burnham 1993; Klein 1993; Tate 1999). Tobacco has economic, social, and political reverberations and is intimately tied to collective images and attitudes. Nonetheless, some simplification is possible: the history of tobacco use can be thought of as the conflict between tobacco as an agent of economic gain and tobacco as an agent of human harm. An exhaustive history would not be content with such a simple contrast, but it serves the purpose of this chapter. The chief barrier to reducing tobacco use—the path of most resistance—is a powerful industry whose efforts to promote tobacco have continued to shape public opinion and social norms. Against this background, the chapter considers the underlying forces

that have motivated the movement to reduce smoking. Many recent events that are of critical historical importance for nonsmoking are considered in other segments of the report (e.g., social advocacy actions [Chapter 7]; taxation-based initiatives in states [Chapter 7]; Food and Drug Administration regulations regarding minors as the target of tobacco advertising [Chapter 5]; and proposed national legislation, settlement and attempted settlement of various lawsuits against the tobacco companies, and criminal proceedings against tobacco companies [Chapter 5]). As noted in Chapter 1, some of the most dynamic changes in the history of smoking control efforts are currently taking place, and we are not sufficiently distanced from these events to evaluate them fully. This chapter will consider, rather, the changing thematic content—religious, hygienic, medical, and social—of the movement to reduce smoking that has presaged the current events.

Early Events

In North America, the history of tobacco use precedes written records. After American Indians introduced tobacco to the European colonists, tobacco was transported from the colonies to Europe, where it quickly became a widely used consumer item. Just as quickly, however, the use of tobacco became controversial. Critics of the day attacked tobacco use as morally irresponsible, extravagant, and a habit of people of base condition (Best 1979). In England, King James I published an antitobacco tract in 1604 that, among other things, offered an early critique of secondhand smoke: the royal author expressed his concerns that a husband who smoked might “reduce thereby his delicate, wholesome, and cleane complexioned wife to that extremitie, that either shee must also corrupt her sweete breath therewith, or else resolve to live in a perpetuall stinking torment” (quoted in Apperson 1916, p. 206). In many countries of northern Europe, tobacco use was criminalized (Best 1979). Part of the objection in England and elsewhere was that trading gold to Spain for tobacco—the best tobacco

came from Spain’s colonies—was dangerous to the state economy. But with the English colonization of Virginia and the growing need in England, and elsewhere in Europe, for more state revenue, governments turned their policies around, despite continued moral objections to tobacco use. King James I himself set aside his previous objections and sought ways for the crown to profit from the tobacco trade (Morgan 1975; Best 1979).

Of all the novel consumer goods the New World made available to the Old World, “tobacco enjoyed the most rapid diffusion” (Shammas 1990, p. 80) among people of different income levels, who bought it on a fairly regular basis. Closer to the source, mass consumption was even more pronounced: in the American colonies during the 18th century, yearly consumption averaged between 2 and 5 pounds per capita (Shammas 1990). When used medicinally, tobacco was favorably regarded; but in its widespread use for pleasure, “it was considered harmful and faintly immoral” (Morgan 1975, p. 91; see also Stewart 1967).

Although that reputation for immorality never entirely vanished, by 1776, tobacco was not only a valued consumer good but also the economic foundation of the colonies' independence movement. "King Tobacco Diplomacy" was a central element in gaining French support for the struggling colonies; tobacco,

one historian reports, "helped to buy American independence" (Morgan 1975, p. 6). Thomas Jefferson thought well enough of tobacco to propose that its leaves be carved into the pillars in one of the Capitol rotundas in Washington (U.S. House of Representatives 1969).

The Rise of the Cigarette

Before the 20th century, tobacco was used predominantly for chewing, pipe smoking, inhaling (as snuff), and cigar smoking. The cigarette was an innovation that appeared sometime early in the 19th century. The term "cigarette" first made its appearance in English in the 1840s (Apperson 1916). For reasons including cost and ease of use (discussed later in this chapter), the product quickly caught on among tobacco users. In the United States, cigarette smoking increased enough during the Civil War for cigarettes to become subject to federal tax in 1864 (Tennant 1950). But it was not until its manufacture was mechanized that the cigarette became a major tobacco product.

James Albert Bonsack patented a cigarette rolling machine in 1881 that, by the late 1880s, produced cigarettes at 40 times the rate of a skilled hand worker (Tennant 1950; Chandler 1977). The mechanization of cigarette manufacture, like that of a number of other products in the late 19th century (such as prepared cereals, photographic film, matches, flour, and canned food products such as soup), precipitated a marketing revolution. Industries that developed "continuous process" production (Chandler 1977, p. 249) could increase unit production without increasing production costs—the main production problem of the day. The cigarette industry, like these others, could now produce almost unlimited quantities of product at minimal cost per additional unit. When James Buchanan Duke installed two Bonsack machines in 1884 and arranged the next year an advantageous leasing arrangement with Bonsack, his cigarette output soared. Within a decade, his unit cost of producing cigarettes dropped to one-sixth of what it had been (Chandler 1977). In 1890, following a series of price wars made feasible by these cost savings, Duke merged with several competitors to form The American Tobacco Company. With the production problem solved and competition reduced, the focus of business thinking

shifted to marketing. At a time when national advertising of many products was in its infancy, The American Tobacco Company was innovative and expansive in its promotional efforts (U.S. Department of Health and Human Services [USDHHS] 1994).

Popularity and Protest

The growing popularity of cigarette smoking coincided with the years of populist health reform in the 19th century. Antitobaccoism was a standard feature of various writings on personal health, which held that any "stimulant" was unhealthy (Nissenbaum 1980). Some of these health beliefs were tied to a religious orientation. Ellen Gould Harmon White, the prophetess who founded the Seventh-day Adventists, spoke out strongly against tobacco. In 1848, her first vision concerning healthful living taught her the religious duty of abstaining from tobacco, tea, and coffee. She attacked these products for the money squandered on them and for their dangers to health. White may have picked up these views from Captain Joseph Bates, a Millerite (follower of William Miller, whose millenarian group believed that the Second Coming of Christ would occur in 1843). Not until 1855, however, did tobacco abstention become a larger theme among the Adventists. In that year, the group's *Review and Herald* printed two lead articles attacking "the filthy, health-destroying, God-dishonoring practice of using tobacco" (quoted in Numbers 1976, p. 40).

This protest was an integral part of the complex antitobacco crusading at the time. In addition to the religious motif, there was the considerable influence of the hygiene movement, which branded "tobaccoism" a disease, tobacco a poison (Burnham 1989, p. 6), and dubbed cigarettes "coffin nails" (Tate 1999, p. 24).

Spearheaded by the American Anti-Tobacco Society, which was founded in 1849, antitobacco critics found tobacco a cause of ailments ranging from insanity to cancer. During this time, cigarettes were often considered narcotics because they seemed to have addicting qualities (Tate 1999). This litany of physiological ills ascribed to tobacco use did not prove to have the social power of the announcement, a century later, that numerous medical studies had found a direct link between smoking and specific diseases that, as was understood only in that later century, often took decades to manifest themselves. Between 1857 and 1872, George Trask published the *Anti-Tobacco Journal* in Fitchburg, Massachusetts, attacking the filth (especially of chewing tobacco), the dangers to health, and the costliness of tobacco (Tennant 1971). Early 19th century popular health movements tended to ally themselves with “nature” and “natural” remedies in opposition to professional medicine; by the late 19th century, health movements were more likely to take medical professionals as their spokesmen (Burnham 1987).

One such professional was Dr. John Harvey Kellogg, Seventh-day Adventist and director of the famous Adventist-founded Battle Creek (Michigan) Sanitarium, whose main concern was improving diet. Kellogg argued that tobacco was a principal cause of heart disease and other illnesses and that it adversely affected both judgment and morals (Schwarz 1970). Along with Ellen Gould Harmon White and her husband, a Millerite preacher, Kellogg organized the American Health and Temperance Association in 1878, which opposed the use of alcohol, tea, coffee, and tobacco. Later, Kellogg served as president of the Michigan Anti-Cigarette Society and, after World War I, as a member of the Committee of Fifty to Study the Tobacco Problem.

Other organizational efforts directed specifically at cigarettes began in the last two decades of the 19th century. These efforts were generally directed at saving boys and young men from the dangers of cigarette smoking. In New York City, the president of the board of education, a smoker himself, set up the Consolidated Anti-Cigarette League and won the pledges of 25,000 schoolboys not to smoke until they turned 21 (Troyer and Markle 1983).

The first to call for cigarette prohibition was the National Woman’s Christian Temperance Union (WCTU) (Tate 1999). Led by Frances Willard, a friend of Harvey Kellogg, who was further inspired by her brother’s death from smoking-related illnesses, the WCTU as early as 1875 made plans to instruct members of its youth affiliate, the Juvenile Work, about the dangers of tobacco, as well as the hazards of alcohol.

In 1883, the WCTU established the Department for Overthrow of Tobacco Habit, which was renamed the Department of Narcotics in 1885 (Lander 1885; Tate 1999).

The campaign against tobacco became a permanent part of the WCTU. Reports from their annual meetings documented the accomplishments of state and local chapters in combating smoking. In 1884, the superintendent of the Department for Overthrow of Tobacco Habit acknowledged the difficulty of the task before her: “With a spittoon in the pulpit and the visible trail of the vice in countless churches, with its entrenchments bearing the seal of respectability, its fortifications so long impregnable will yield slowly and unwillingly to the mightiest opposing forces” (WCTU 1884, p. v). She noted that tobacco was a habit costing people “more than the support of all [their] ministers of the gospel” or than the price of educating their children; that it caused disease, “especially the loss of sight, paralysis, prostration, and scores of ailments hitherto credited to other sources”; and that it “lower[ed] the standard of morality” (WCTU 1884, p. v).

The WCTU was one group that pressed with some success for legislation to prohibit the sale of tobacco to minors.¹ By 1890, such laws had been passed in 23 states. Connecticut and New York enacted penalties for both the underaged smoker and the merchant who sold to the minor (WCTU 1890). In New York, the strengthened law arose out of WCTU lobbying. “We found so many evasions of the law as it stood,” the WCTU reported at its annual meeting in 1890, “that we decided our only way to save the boys was to amend the law, so as to punish the boy who was found using tobacco in any public place, street or resort” (WCTU 1890, p. 185). The Department of Narcotics organized a letter-writing campaign that mobilized women, educators, and ministers (p. 185). By 1897, the Department of Narcotics report could proudly claim, “everything points to the death of the little coffin nail, if our women will only continue faithful” (WCTU 1897, p. 343).

¹The laws prohibiting sales to minors began in New Jersey and Washington as early as 1883, Nebraska in 1885, and Maryland in 1886. By 1940, all states except Texas had laws of this sort on the books (Gottsegen 1940). By 1964, Texas had joined the list, but Louisiana and Wisconsin had repealed their laws as unenforceable (USDHHS 1989). The legality of the laws was confirmed by the United States Supreme Court (*Austin v. Tennessee*, 179 U.S. 343, 21 S. Ct. 132 [1900]), and a Federal Court of Appeals ruled in 1937 to uphold the authority of local jurisdictions to ban vending machine sales of cigarettes in the effort to protect minors (USDHHS 1989).

Announcements of tobacco's death were premature, but cigarette sales declined in the last years of the 19th century. Most likely, the decline was precipitated by the "Plug War," in which The American Tobacco Company bought several plug tobacco producers and sharply cut prices, attracting cigarette users back to other tobacco products. Moreover, as the country came out of the depression of the 1890s, cigar smokers who had shifted to the cheaper cigarettes moved back to their preferred smoke (Sobel 1978). But the campaign against the cigarette certainly had a legislative impact. Cigarettes were prohibited for both adults and minors by law—if only temporarily—in North Dakota in 1895, Iowa in 1896, Tennessee in 1897, and Oklahoma in 1901. Eleven states had some general anticigarette legislation by 1901, and almost all state legislatures had considered curbs on cigarette sales (*Outlook* 1901).

In 1899, Lucy Page Gaston, a WCTU activist, set up the Chicago Anti-Cigarette League (changed to the National Anti-Cigarette League in 1901 and to the Anti-Cigarette League of America in 1911). The league focused on the dangers of cigarettes to boys. Gaston sponsored frequent rallies, at which a chorus of young nonsmoking men provided the music (Duis 1983; Tate 1999). One of the innovations of Gaston's crusade was the establishment of a smoking cessation clinic in Chicago (Troyer and Markle 1983). Gaston, whose long career against tobacco would culminate with her bid for the Republican presidential nomination in 1920 on an antitobacco platform (*New York Times* 1920), worked tirelessly lobbying for antitobacco legislation.

Such legislation continued to pass, particularly in midwestern and some western states—Indiana, Nebraska, and Wisconsin in 1905; Arkansas in 1907; and Kansas, Minnesota, South Dakota, and Washington in 1909. But evasion of the laws was apparently easy. Cigarette "makings" (e.g., cigarette papers and cigarette tobacco) were sold even if cigarettes were not, and some retailers sold matches for a higher-than-usual price and gave away cigarettes with them (Warfield 1930; Sobel 1978). Other retailers and smokers evaded the law through a product wrapped in a tobacco leaf rather than paper (*New York Times* 1905).

The WCTU was not alone in its efforts. Several businesses and prominent individuals were outspoken in the crusade against tobacco use, some going so far as to support Gaston's proposed (and defeated) 20th amendment to the Constitution that would have outlawed the manufacture and shipment of tobacco products (Junod 1997). Henry Ford attacked the habit of cigarette smoking and enlisted Thomas Edison to investigate its dangers (Brandt 1990). According to

Harper's Weekly (1910), many railroads and other firms would not hire smokers. Sears, Roebuck and Company and Montgomery Ward Holding Corporation refused to employ smokers (Porter 1947–48). The Non-Smokers' Protective League of America was established in 1911 with a distinguished board of directors, including Harvey W. Wiley, chief chemist of the U.S. Department of Agriculture and father of the (1906) Pure Food and Drug Act; James Roscoe Day, chancellor of Syracuse University; and David Starr Jordan, president of Stanford University (*New York Times* 1911). Dr. Charles G. Pease, a physician and dentist, was the leader of this group. "Almost single-handed," according to a *New York Times* report (1928, p. 7), Pease won a 1909 prohibition against smoking in the subways. In 1917, he opposed sending tobacco to American soldiers in Europe.

But the *New York Times* reported in 1928 that "little has been heard from Dr. Pease since" (p. 7). Indeed, the anticigarette movement by then was waning. Cigarette prohibition was repealed in Indiana in 1909; Washington in 1911; Minnesota in 1913; Oklahoma and Wisconsin in 1915; South Dakota in 1917; Nebraska in 1919; Arkansas, Idaho, Iowa, and Tennessee in 1921; Utah in 1923; North Dakota in 1925; and Kansas in 1927 (Gottsegen 1940). Legislatures in other states—including Lucy Page Gaston's home state of Illinois—considered but did not enact anticigarette bills (Duis 1983). Even the WCTU, at the time judged "the most powerful and the most formidable organization which is actively opposing the use of tobacco" (Brown 1920, p. 447), in 1919 voted against supporting tobacco prohibition. The organization pledged to keep to an educational rather than a legislative campaign (*New York Times* 1919).

A major weapon against the tobacco prohibition movement was the American soldier. Cigarettes had been popular among the armed forces since the Civil War. By 1918, during World War I, cigarettes were part of the army's daily ration (Dillow 1981); soldiers used cigarettes for relief during the extremes of tedium and tension characteristic of the profession. General John Joseph Pershing himself is supposed to have said, "You ask me what we need to win this war. I answer tobacco, as much as bullets" (quoted in Sobel 1978, p. 84). "The soldiers, we are told, must have their tobacco," a newspaper editorialized in 1915: "The cigarette is the handiest form in which this can be sent" (*Lynn [Mass.] Evening News* 1915, p. 4). Even the Young Men's Christian Association altered its antitobacco stance and, along with the International Red Cross and other charitable and patriotic organizations, sent cigarettes off to the soldiers in the field (Schudson 1984).

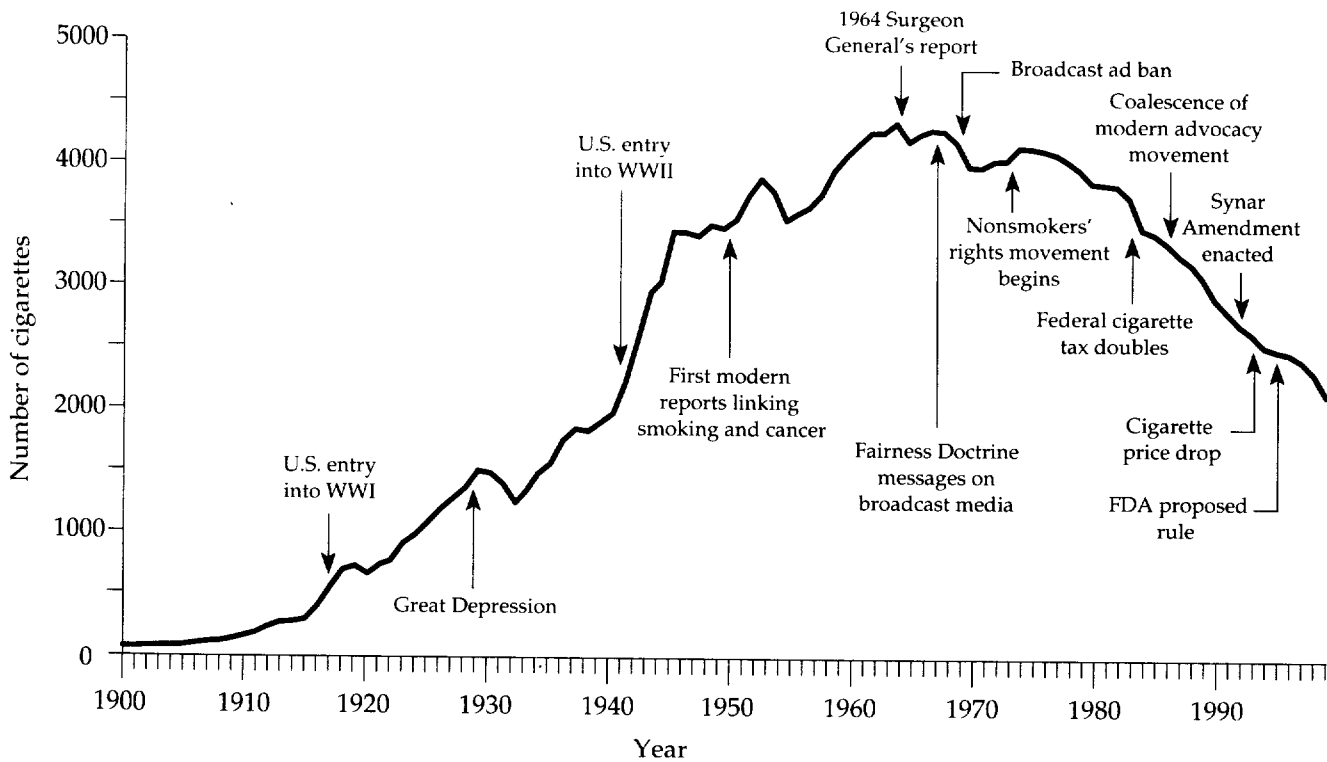
This outspoken, soldier-directed sentiment in favor of the cigarette was thus a large-scale factor in the reversal of anticigarette laws. A representative question that fueled the repeal effort in Kansas in 1927 was, "If cigaret[te]s were good enough for us while we were fighting in France, why aren't they good enough for us in our own homes?" (*Literary Digest* 1927, p. 12; see also Smith 1973).

Weakened but not vanquished by these legislative setbacks, the war on tobacco persevered. In 1921, the Loyal Temperance Legion reported holding anticigarette essay contests, distributing antitobacco blotters in schools, and stubbing out 125,000 cigars and cigarettes (WCTU 1921). The Department of Narcotics held up its own end; in 1929, for instance, it held poster contests, cooperated in antitobacco work with

other civic organizations, sponsored 214 debates on tobacco, and ran essay contests producing more than 50,000 essays against tobacco use (WCTU 1929). Religious denominations, including the Presbyterians, Methodists, and Baptists, also took a stand against tobacco (Troyer and Markle 1983). The antitobacco position was especially strong among the Mormons (Latter-day Saints). A motto of the Mormon youth organization in 1920, "We stand for the non-use and non-sale of tobacco" (quoted in Smith 1973, p. 360), seems to have presaged the current low prevalence of tobacco use in Utah.

Such dedicated opponents did not prevent the popularity of the cigarette—an inexpensive, easy-to-use form of tobacco product—from increasing in the 1920s (Figure 2.1; the demographic and epidemiologic

Figure 2.1. Adult per capita cigarette consumption and major smoking and health events, United States, 1900–1999



Note: The 1999 data are preliminary.

Sources: Adapted from Warner 1985; U.S. Department of Health and Human Services 1989; Creek et al. 1994; U.S. Department of Agriculture 2000.

details of cigarette consumption have been documented in detail in prior reports [USDHHS 1989, 1994] and will not be repeated here). Men in substantial numbers either switched from other tobacco forms or took up smoking, and women in smaller but visible numbers began taking up tobacco use—in the form of cigarette smoking—for the first time, even as the frequently women-led antitobacco efforts continued. By the 1930s, cigarettes accounted for more than one-half of all tobacco consumption (Schudson 1984).

In response to these trends, the WCTU campaigned for strict enforcement of laws forbidding the sale of tobacco to minors, attacked advertising that claimed or suggested health benefits, and criticized smoking among women. In 1927, the Department of Narcotics reported that chapters across the country had sponsored thousands of antismoking events and strategies. For example, the Portland, Oregon, chapter successfully protested a leading department store's use of a female mannequin holding a cigarette. Members stubbed out 219,560 cigarettes and 39,713 cigars. The WCTU also lobbied for laws prohibiting smoking in places where food was displayed for sale and reported that 21 states had enacted such laws (Schudson 1993).

As the cigarette's popularity increased, so did concerns about its health consequences. Serious research of the day sought to link tobacco with a variety of conditions (Burnham 1989), but uncovered little new ground (Tate 1999), while sobering results were often lost amid a welter of overblown charges. For example, the common observation at the time that cigarette smokers seemed more dependent on their habits than other tobacco users, now explained by increased blood nicotine levels (Tate 1999), led one writer in 1912 to warn that users would naturally progress from tobacco to alcohol to morphine (Sinclair 1962). Similar unsubstantiated charges have often made better headlines than the results of serious scientific studies over the years. In 1930, one doctor claimed that 60 percent of all babies born to mothers who smoked died before reaching the age of two (Sinclair 1962). Smoking was said to depress intelligence and academic achievement (Troyer and Markle 1983). One historian writing in 1931 recalled a widely distributed antismoking poster that wordlessly voiced these concerns by showing a woman who had a cigarette in her mouth and was holding a baby; the poster bore "no words—the mere presentment, it was hoped, would have a deterrent effect" (Corti 1931, p. 266).

That image of mother and child projected an anti-smoking message that, typical of its time, contained both a moral and a medical objection to smoking. Historian Allan M. Brandt has observed that antitobacco

crusaders early in the century "saw no tension in seeing the cigarette as ungodly *and* unhealthy; they equated moral dangers and health risks" (Brandt 1990, p. 159). A 1925 WCTU pamphlet held that because the brain's higher functions develop last, youthful smokers would have "impaired morals, weak will, lack of religious and spiritual development, and a shocking incapacity for unselfishness and consideration of the rights of others" (p. 9). One of the moral dangers that remained a theme in anticigarette propaganda was the danger smoking posed to thrift, as cigarettes were a needless expense, especially among the poor (Brown 1920).

Although anticigarette crusaders had medical objections to smoking, they did not have any medical consensus behind them. Medical opinion was generally noncommittal. Most physicians counseled that tobacco in moderation was not harmful (*Hygeia* 1928; Tobey 1930; Johnson 1932). Media reports even located medical research that suggested that smoking had health benefits. During World War I, army surgeons praised cigarettes for providing the wounded relaxation and relief from pain (*New York Times* 1918); a Paris physician claimed that tobacco use might prevent the development of microbial infections (*New York Times* 1923); and a famous mountain climber said that smoking helped breathing at high altitudes (*New York Times* 1922).

Without a strong medical component, the objection against tobacco use was scarcely distinguished from any number of other protest targets of the reform movement early in the century. Lacking as strong an opponent as, for example, the alcohol temperance movement, tobacco use continued unabated. In the instance of cigarettes, use proliferated.

The Attraction of Cigarettes

Throughout its boom period, from the 1920s until the mid-1960s, cigarette smoking was generally regarded as a consumer activity rather than as a medical problem. In its commercial essence, the cigarette is simply a "package," as a Philip Morris Companies Inc. memorandum has suggested, for a "product" (*Cipollone v. Liggett Group, Inc.*, 505 U.S. 504, 112 S. Ct. 2608 [1992], cited in Lynch and Bonnie 1994, p. 60). In fact, the cigarette is by far the most commercially successful package for the product—tobacco, itself a delivery device for nicotine—yet devised. Such thinking fits well with the notion that consumption is an act of imagination—that is, that one buys not the product but rather the attributes for which the product is merely the vehicle (Fox and Lears 1983).

Each vehicle for nicotine delivery has different social propensities. The unique qualities of the cigarette as a tobacco form were critical in its role as the agent through which tobacco use was made both available and acceptable to all social classes. Put simply, cigarettes not only made tobacco cheaper (through automated production) but also easier to use. This utility stemmed from several distinctive features that separated cigarettes from other modes of tobacco use and fueled the spread of the smoking habit.

The first distinctive feature of the cigarette is its mildness. This attribute, along with its inexpensive unit cost, made the cigarette especially appealing to boys. Before the cigarette became popular, adolescent males were likely to first try smoking by using cigars, a practice that required a degree of skill to draw in but not inhale the strong smoke. The unpleasant side effects resulting from failing this tobacco rite of passage were largely avoided when new smokers tried cigarettes, which used a milder form of tobacco that was meant to be inhaled. Many of the legislative efforts during the 1890s and after were directed not at tobacco use generally but at cigarettes exclusively because they were so accessible to boys and young men and because they were inhaled (*Outlook* 1901). A 1907 Wisconsin court decision used this issue of adolescent accessibility to justify a regulatory distinction between cigarettes and other forms of tobacco. The cigarette, the decision stated, was able “. . . to remove the protection which nature placed in the way of acquiring habits of use of the more vigorous tobacco commonly used in cigars. Before the day of the cigarette, mastery of the tobacco habit was obstructed by agonies of nausea usually sufficient to postpone it to a period of at least reasonable maturity” (*State v. Goodrich*, 113 N.W. 388, p. 390 [Wis. 1907]).

Mildness was especially characteristic of cigarettes smoked after the 1870s, when cigarette tobacco was made milder by being flue-cured rather than fire-cured. Moreover, the stronger Turkish tobaccos that were popular in the early 20th century became unavailable with the interruption of trade during World War I; thus, blended American tobaccos came into wider use, making the cigarette an even milder product than before (Tennant 1950).

The inhalability of the milder tobaccos used in cigarettes is the source of a second important distinction between cigarettes and other forms of tobacco. Because the smoke of pipes, cigars, and dark tobacco is relatively alkaline, its nicotine dose is absorbed through the linings of the mouth and nose. Flue-cured “blond” or light-colored tobacco, from which American cigarettes are normally blended, produces slightly

acidic tobacco smoke; the nicotine dose thus must be inhaled to be absorbed. Drawn into the lungs through cigarette smoking, nicotine is absorbed into the systemic circulation more quickly than in other forms of smoking—hence the greater potential for nicotine addiction (Lynch and Bonnie 1994).

A third distinctive feature of the cigarette is its relative convenience and disposability. This mild and quickly consumed tobacco product seemed to contemporaries “peculiarly adaptable to the temperament of the American people in an age when things are done hurriedly and yet with greater efficiency than at any previous time” (Young 1916, p. 119). The *New York Times* editorialized in 1925 that the cigarette was “short, snappy, easily attempted, easily completed or just as easily discarded before completion—the cigarette is the symbol of a machine age in which the ultimate cogs and wheels and levers are human nerves” (*New York Times* 1925, p. 24). Facility of use was further augmented by the introduction of the safety match just before World War I (Burnham 1989).

In short, cigarettes had a “natural adaptability” to the rhythms of urban life (Tennant 1950, p. 142). Cigarettes fit more easily than other forms of tobacco into brief moments of relaxation, they were more readily used while working, and they were more easily managed without the use of one’s hands. Cigarettes helped combat the tedium of industrial work. Particularly before workplace smoking restrictions were widespread, cigarettes could, in the words of one commentator, “not only help pace out a day—on the production line, in the typing pool, behind a lunch counter or waiting on a welfare line—but they could give you a steady flow of small rewards to keep on trucking” (Blair 1979, p. 33). Cigarettes organized and controlled the passage of time; a cigarette, writes Richard Klein, is “a clock” (Klein 1993, p. 24).

After World War I, cigarettes, which were less costly to use than cigars or pipe tobacco, became part of a more general “throwaway ethic” reflected in other consumer developments of the day (Busch 1983). The disposable razor blade came into widespread use during and after World War I (Schudson 1984); in 1927, U.S. wristwatch production surpassed pocket watch production, as the more conveniently consulted wristwatch had won favor among soldiers (Busch 1983).

Changing attitudes about hygiene also stimulated this predilection for convenience and disposability. Between 1909 and 1936, 45 states banned the common drinking cup used in public facilities such as railroads; the railroads became the first principal customers for the paper cup and paper cup dispensers (Busch 1983). Disposable sanitary napkins and

Kleenex tissues also became mass-market items for the first time in the 1920s (Busch 1983). From a strictly hygienic perspective, the cigarette appeared to give a cleaner smoke than the cigar. A Lucky Strike advertisement directly contrasted the neatness of cigarettes to the messiness of cigars, which require more oral manipulation: "Spit Is an Ugly Word, but It's Worse on the End of Your Cigar" (Tennant 1950, p. 286). This advertisement also played on an earlier scandal in which cigar makers were purported to have used spit to seal the cigar's leaf wrapper (John C. Burnham, telephone conversation with Richard B. Rothenberg, May 25, 1995). For a generation working in offices and riding to work in subways, streetcars, and automobiles, milder smoke was less irritating to others. Both the strong fumes of cigar and pipe smokers and the unsightly by-products of snuff and chewing tobacco users were generally more objectionable than the smoke and ashes of cigarette smokers. Historian Cassandra Tate has concluded that one of the lessons of the first antismoking campaign is that "any successful social reform movement carries within it the seeds of a backlash" while "incessant warnings can fade into the ozone of the commonplace" (Tate 1999, p. 155).

An important part of the cigarette's convenience was its readiness of use. Some smokers still rolled their own cigarettes in the 1920s and 1930s, but these consumers were a small segment of the market (Tennant 1950). By far, most smokers during these key decades of rising cigarette popularity used cigarettes prerolled by the manufacturer. (Cigars were also prerolled, but by hand rather than by machine, and thus at considerable expense to the buyer.) The cigarette's ready-made convenience was immediately apparent when compared with, for example, the care required to load a pipe so that it burned neither too quickly (thereby overheating the bowl) nor too slowly (thereby requiring frequent relighting). The cigarette was far more easily lit and drawn than other smoked tobacco products.

One final distinctive feature of the cigarette is its cultural connotation as a minor moral transgression. Smoking cigarettes is—and has always been—considered slightly illicit. A practice that "looked so strange, felt so pleasant, accomplished so little, and cost so much [although less than cigar or pipe smoking] could not be unopposed" (Tennant 1950, p. 115). The pleasure it offers is culturally mediated—that is, part of the pleasure of smoking is the guilt connected with it. None of the marketing efforts of the tobacco giants ever fully legitimized the image of smoking—and there is some suspicion that they never meant to (Burnham 1993). As one sympathetic cultural observer has put it, part of the seductive quality of the cigarette

is "beauty [that] has never been understood or represented as unequivocally positive; the smoking of cigarettes, from its inception in the nineteenth century, has always been associated with distaste, transgression, and death" (Klein 1993, p. xi). A modern parallel is the recent cachet of smoking as a sexual fetish, with images available on the Internet (Hwang 1996, p. 5). Culturally, in fact, interviews have shown that cigarettes became a generational marker for the transforming generation that had come of age during World War I, as well as for the reform-minded generation of the Vietnam War era (Tate 1999).

Women and Cigarettes

Several features of the cigarette helped make it a particularly suitable product for, and symbol of, the liberation of women, who came to smoking in growing numbers beginning in the 1920s. Just as the cigarette "fairly leaped" into its rightful position as "the smoke of manly men" with the aid of stories and pictures from the World War I front (*[New York] Tobacco Leaf* 1914, p. 6, quoted in Young 1916, p. 228), so for young women after the war smoking was "perhaps the one most potent symbol" of the new sense of freedom and equality (Fass 1977, p. 292). For the growing number of women who attended college in the 1920s, smoking was "a welcome form of notoriety" (p. 293). Objections to women's smoking betrayed a traditional double standard, for such opposition arose from the twin cultural perceptions that cigarettes were not moral and were not feminine. Smoking "implied a promiscuous equality between men and women and was an indication that women could enjoy the same vulgar habits and ultimately also the same vices as men" (p. 294). But while they were tokens of equality with men, cigarettes were also amorphous, making men appear more manly and women more womanly (Tate 1999).

Aware of (and perhaps sharing) these objections, cigarette manufacturers were initially cautious about targeting this potential new market. As late as 1924, the editor of a tobacco trade journal wrote that "all responsible tobacco opinion [found the idea of women smoking so] novel... that it would not be in good taste for tobacco men as parties in interest to stir a particle toward or against a condition with whose beginnings they had nothing to do and whose end, if any, no one can foresee" (Wessel 1924, p. 6). Even advertisements with women in mind did not dare picture them actually smoking.

This initial caution was dictated by canny attention to the political environment. Cigarette manufacturers feared a backlash in legislation or public opinion if they too aggressively sought female consumers (Tennant 1950). In light of anticigarette legislation arising during the 1920s, and particularly in light of the ongoing experiment in alcohol prohibition, this anxiety was reasonable.

The cigarette industry's caution was short-lived. As the 1920s advanced, appeals to women through tobacco marketing were increasingly direct. In 1926, the Chesterfield brand ran a then-controversial advertisement wherein a woman urged a male companion to "Blow Some My Way" (Ernster 1985, p. 336). In 1927, Lucky Strike advertisements showed a famous female opera star recommending Luckies as soothing to the throat and a famous actress assuring readers that Luckies did not irritate the throat (Schudson 1984). And in 1928, Luckies were advertised with the diet-conscious slogan, "Reach for a Lucky Instead of a Sweet" (Ernster 1985, p. 336).

Winds of Change

The industry's direct appeal to the new market of female smokers likely reflected less boldness than it did a recognition of a prevailing wind of cultural change, of which the women's movement was only a single component. In the 1920s, on the heels of the 19th Amendment, women's growing assertion of their equality with men was part of a larger shift in American culture, the move to a more modern culture from the somewhat puritanical milieu that supported the populist reform movement. In the language of one observer, the change was from a culture of middle-class respectability to one of "lower-order parochialism" sponsored and encouraged by industries that catered to the minor vices (Burnham 1993, p. 16). The 1920s saw the triumph of "a new behavioral ethic" (Brandt 1990, p. 157), one of consumerism and self-indulgence rather than the self-denial that had been, for example, the traditional lot of women. Through the marketing of cigarettes, the tobacco companies strategically exploited this development among the less puritanical and self-recriminating members of both sexes.

Even at the time, opinion was divided on whether the massive marketing efforts of the cigarette giants motivated the change toward a society of smokers or only took advantage of a cultural and behavioral shift already under way. In 1940, by which time the

cigarette had clearly triumphed over other forms of tobacco, one study of the tobacco industry concluded, "how much of increased cigarette consumption is due to advertising and how much to fashion is impossible to determine. The latter influence is still imponderable" (Gottsegen 1940, p. 204).

Fashion and advertising were not the only two factors. Three other matters were potentially important: (1) the physical product itself was not a constant, (2) the price was variable, and (3) society changed in ways that influenced consumption. For example, before the explosion of cigarette marketing in 1914 (Burnham 1989), men smoked more than women, the rich smoked more than the poor, and urban dwellers smoked more than rural inhabitants. (For a more comprehensive account of the demographic dynamics, see USDHHS 1989.) With growth in the movement for women's equality, a rising per capita income in real dollars, and the long-term trend toward urbanization, there would likely have been an increase in cigarette sales even if tobacco companies had not marketed the product aggressively.

Regardless of what directed the impetus, per capita consumption of all forms of tobacco was remarkably steady from 1913 to 1945 (Figure 2.1), rising when real income per capita rose, falling when real income fell (Tennant 1950). The spectacular growth in cigarette consumption reflected not only the introduction into the tobacco market of new consumer groups (such as women) but also, as was previously noted, a major shift among existing male smokers from other forms of tobacco use to the cigarette. Annual per capita consumption of tobacco hovered at 7 pounds from 1915 through the late 1930s, except for a transient decline in the early 1930s that was coincident with a drop in per capita income in the early years of the Great Depression (Tennant 1950). It is possible, however, that actual consumption of tobacco per unit of weight increased because of less work in both the manufacturing and the use of the increasingly popular cigarette. World War II, like World War I, served to increase and promote cigarette smoking, to which numerous war novels, movies, and other public images testify (Klein 1993). A 1943 treatise observed that the cigarette achieved a heroic standing from its association with soldiers during World War II (Gehman 1943). In short, between about 1920 and 1950, "cigarettes became an acceptable and noncontroversial part of U.S. life" (Troyer and Markle 1983, p. 124).

Medical Warnings

Medical opinion at first took little heed of the growing popularity of cigarettes. Physicians tended to take an ambivalent or qualified position on the cigarette phenomenon. For instance, although Dr. James J. Walsh wrote in 1937, "We physicians of the older generation who have seen the smoking of cigarettes grow from what seemed scarcely more than a toy into what is now one of the most significant of social institutions are under an obligation to the rising generation to warn them of the serious dangers associated with the abuse of cigarettes in our day" (Walsh 1937, p. 665), even Walsh admitted to smoking an occasional cigarette himself. He further attested that many doctors he knew smoked 20 or 30 cigarettes a day and yet were "as healthy as the proverbial trout" (p. 665). He held that "not the cigarette smoke so much as the excess of it" (p. 665) brought about serious conditions like Buerger's disease.

The Puritan temperament that had fueled anticigarette activity early in the century was on the defensive. Antipathy to Puritan moralism was strong enough to weaken faith in any research tainted by it. For example, Alton Ochsner's suggestions in the 1930s and 1940s of a connection between cigarette smoking and lung cancer were discounted by his colleagues because he was known to be "an anti-smoking enthusiast" (Burnham 1989, p. 18). During these crucial times when cigarette smoking became widespread, "physicians tended to absorb the common sense of the general population" (p. 11). By the 1930s, common sense, in some measure influenced by the advertising claims of the era, held that smoking in moderation was not a health hazard (Burnham 1993).

In 1938, Raymond Pearl published one of the first significant epidemiologic studies that indicated smoking to be "statistically associated with an impairment of life duration" (Pearl 1938, p. 217, quoted in Breslow 1982, p. 134; see also Brandt 1990). But only in the late 1940s and early 1950s did definitive evidence begin to accumulate from various sources and studies showing the association between cigarette smoking and overall mortality. First retrospective and then large-scale prospective studies confirmed that smoking was associated with higher death rates; excess mortality was especially pronounced for coronary artery disease and lung cancer.

In the late 1940s and early 1950s, research linked lung cancer to smoking. The initial report by Wynder

and Graham (1950) just preceded an article by Doll and Hill (1950). Subsequent articles by Doll and Hill (1952), Levin (1953), and others confirmed the association. Levin's contribution was of particular interest, because he derived the formula for attributable risk in a footnote to the article—an overt demonstration of the link between the smoking etiology and the emerging methodology of epidemiologic analysis.

Public Dissemination

The findings from these and other studies of the era were publicized in a 1952 *Christian Herald* article. In December 1952, that article was reprinted in the widely circulated magazine *Reader's Digest* as "Cancer by the Carton" (Norr 1952). Popular concerns aroused by this publicity apparently led to an almost immediate decline in cigarette consumption (Tennant 1971). The decline was temporary but severe enough to lead the tobacco companies to step up their market promotion of the relatively new filter-tip cigarette. Originally intended to attract new smokers by offering a milder smoking experience, the filtered cigarette assumed a marketing prominence that was seen as a tacit acknowledgment that there might be a health risk in smoking (*Fortune* 1953). Whether for smoking comfort or for supposed health advantage, the market share of filter brands increased from less than 1 percent in 1952 to 73 percent in 1968 (Tennant 1971).

The nonprofit consumer advocacy organization Consumers Union paid attention to smoking throughout the 1950s. Early mentions in the organization's monthly magazine *Consumer Reports*, like so much commentary elsewhere, warned only against excessive smoking. In 1953, *Consumer Reports* found the evidence connecting smoking to lung cancer "suggestive" and recommended that until further research results were available, "those who can" should reduce smoking to a "moderate" level, which was defined as not more than one pack a day (p. 74). In the same issue, however, the magazine reminded readers that smoking had health benefits; specifically, smoking reduced "the inner nervous tensions and strains resulting from man's exposure to the stresses and responsibilities imposed by society" (p. 74). Smoking, the magazine further observed, relieved such pressure in a way less harmful than alcohol or overeating (*Consumer Reports* 1953).

In 1954, medical advisers for Consumers Union spoke more strongly about the research link between smoking and lung cancer, but the organization remained vague in its advice to smokers (*Consumer Reports* 1954). In the absence of further scientific support, this tentativeness was not surprising. It was hard to imagine that a habit so widespread, so apparently normal, so integrated into American culture, and so ennobled by its wartime use could turn out to be fundamentally destructive. In 1954, the American Cancer Society's (ACS) Tobacco and Cancer Committee adopted a resolution recognizing an association between cigarette smoking and lung cancer (Breslow 1982), but the board of directors did not consider the possibility of a causal association. Efforts of the physician members of the board were blocked by lay members in meetings that were themselves "filled with smoke" (Breslow 1977, p. 849).

By 1958, Consumers Union agreed that the medical research provided nearly definitive evidence on the risk of lung cancer posed by smoking. The organization further argued that smokers should not try to allay their concerns by switching to filter cigarettes, as no evidence indicated that filters reduced the risk of cancer. Smokers were thus advised "to cut out or cut down" on cigarettes (*Consumer Reports* 1958, p. 636).

Toward a Medical Consensus

With growing sentiment, in and beyond the medical community, that there were serious risks to tobacco use, government agencies became more concerned about tobacco advertising that stated or implied health benefits to the cigarette. Several times during the 1950s, the Federal Trade Commission (FTC) issued orders against cigarette advertising that made health claims. Congress also took an interest in tobacco advertising; in 1957, Representative John A. Blatnik (D-MN) held hearings on deceptive filter-tip cigarette advertising (Neuberger 1963). The Surgeon General first brought the Public Health Service into the scene by establishing a scientific study group in 1956 to appraise the effects of smoking on health. The study group determined that there was a causal relationship between excessive smoking of cigarettes and lung cancer. Surgeon General Leroy E. Burney issued a statement in 1957 that "the weight of the evidence is increasingly pointing in one direction: that excessive smoking is one of the causative factors in lung cancer" (Burney 1958, p. 44). In an article he subsequently published in the *Journal of the American Medical Association*, Burney reiterated this view and went even

further: "The weight of evidence at present implicates smoking as the principal etiological factor in the increased incidence of lung cancer" (Burney 1959, p. 1835).

Much of the medical profession, however, remained ambivalent on the issue. In an editorial several weeks after Burney's article, the journal itself argued against taking the Surgeon General too seriously: "Neither the proponents nor the opponents of the smoking theory [that cigarette smoking causes cancer] have sufficient evidence to warrant the assumption of an all-or-none authoritative position" (Talbot 1959, p. 2104).

In June 1961, the presidents of the ACS, the American Public Health Association, the American Heart Association (AHA), and the National Tuberculosis Association (later the American Lung Association [ALA]) urged President John F. Kennedy to establish a commission to study the health consequences of smoking (U.S. Department of Health, Education, and Welfare [USDHEW] 1964). Early in 1962, representatives of these organizations met with Surgeon General Luther L. Terry, who then proposed establishing an advisory committee to assess available knowledge and make recommendations concerning smoking and health. In April, Terry provided the Secretary of Health, Education, and Welfare a fuller proposal asking to reevaluate the Public Health Service's position on smoking. Among the factors prompting his call for action, Terry cited new studies on the adverse consequences of smoking, the 1962 Royal College of Physicians report (which had been summarized that year in *Reader's Digest* [Miller 1962]), and other evidence of a shift in medical opinion against smoking as well as similar views among the national voluntary organizations. Terry also pointed to efforts to reduce tobacco use in Britain, Denmark, and Italy; to Senator Maurine (Brown) Neuberger's (D-OR) proposal that Congress create a commission on smoking; and to a request from the FTC for guidance on the labeling and advertising of tobacco products.

In the summer, Terry announced the appointment of a committee to review all of the data on the medical effects of smoking. The committee was established after consultation with representatives of relevant government agencies, the voluntary health organizations, the American Medical Association (AMA), the American College of Chest Physicians, and the Tobacco Institute. Each organization was empowered to veto any names proposed for the committee; people who had taken public positions on the questions at issue were eliminated from consideration.

While the committee reviewed the data, actions were being urged or taken in response to the evidence that had emerged. Leroy Collins, former governor of Florida and president of the National Association of Broadcasters, urged broadcasters in 1962 to "make corrective moves" on their own to limit or regulate tobacco advertising to which children might be exposed. "We cannot ignore the mounting evidence that tobacco provides a serious hazard to health," he asserted (*New York Times* 1962, p. 71). Also in 1962—a busy year for efforts to reduce smoking—Air Force

Surgeon General Major General Oliver K. Niess ordered an end to the distribution of free cigarettes in Air Force hospitals and flight lunches (Neuberger 1963). Smoking education was a growing phenomenon in public schools, where materials were provided by the ACS and other voluntary organizations. Church groups (particularly the Seventh-day Adventists) and temperance organizations continued their campaign against smoking. And although the AMA remained silent on the issue, at least eight state medical societies had adopted resolutions on smoking and health.

Turning Point: The Surgeon General's Report

Social movements may be precipitated or strengthened by events that "dramatize a glaring contradiction between a highly resonant cultural value [such as health] and conventional social practices [such as smoking]" (McAdam 1994, p. 40). Rarely in social history, however, can a single such event be identified as a key source of social change. The publication of the 1964 Surgeon General's report on smoking and health might qualify as such a rarity. The Surgeon General's report consolidated and legitimized 15 years of growing evidence of the dangers of smoking to health (USDHEW 1964). Its publication "marked the beginning of a revolution in attitudes and behaviors relating to cigarettes" (Brandt 1990, p. 156). "Beginning" should be stressed, because abandonment of cigarettes was not precipitous. Smoking prevalence did begin a persistent but hardly precipitate decline in 1965 of 0.5 percent per year (USDHHS 1989). Cigarette sales kept increasing and would not peak until the late 1970s. Although per capita cigarette consumption reached its highest level in 1963, the year before the report's publication, it did not begin a steady year-to-year decline until 1973 (USDHHS 1994).

Thus, the Surgeon General's report was certainly a pivotal event, but it did not change smoking patterns overnight. Why this was so—why people did not, upon learning of the report's findings, immediately cease either beginning or continuing to smoke—is a complex phenomenon, even if one disregards the major role of nicotine addiction. On the one hand, a change in behavioral norms can be precipitated by a change in what people generally believe. On the other hand, people do not always act in their own

best interests, even in response to clearly stated facts (Schudson 1984; USDHHS 1989). The outcome in a conflict between cultural mores (in this instance, beliefs instilled through the social, behavioral, and physiological habit of smoking, reinforced by marketing) and scientific fact (as represented in the widely publicized findings of the Surgeon General's report) often depends on how the latter is diffused—that is, on whether new information can become so broadly and effectively transmitted and received that it becomes accepted knowledge that then supplants habit. As one sociologist has observed, "The diffusion of new knowledge is a major cause of collective searches for new norms in the modern world" (Davis 1975, p. 53).

A Stubborn Norm

In the case represented by the Surgeon General's report, the diffusion of new knowledge was impeded by the entrenched norm of smoking, a widespread practice fueled by the persistent and pervasive marketing of cigarettes (see "Advertising and Promotion" in Chapter 5). During the decade preceding the report, many social norms were established or strengthened through the dominant new mass medium, television. Whatever effect television advertising had on cigarette sales, the constant presence of cigarettes both in advertisements and in the real and imaginary lives of the medium's "stars" was a strong force in reinforcing smoking as a norm. Furthermore, TV-related marketing coincided with, and helped bring to the public's attention, the availability of the filter-tipped cigarette—thereby not only reinforcing the

smoking norm but also helping screen the imputed health hazards of smoking (USDHHS 1994).

The smoking norm could be found in the most unlikely settings and thus gave rise to considerable cognitive dissonance. The first significant government response to the report was the FTC's 1964 ruling that warning labels be required on cigarette packs and that tobacco advertising be strictly regulated (see "Attempts to Regulate Tobacco Advertising and Packaging" in Chapter 5). The resulting legislation that was passed, however (the Federal Cigarette Labeling and Advertising Act of 1965 [Public Law 89-92]), undermined much of the original proposal's strength by requiring a more weakly worded warning label than the FTC had proposed (USDHHS 1994). Furthermore, the act not only preempted the FTC's ruling but also prohibited the FTC or any other federal, state, or city authority from further restricting cigarette advertising until after the expiration of the law on June 30, 1969. In 1969, former Surgeon General Terry would refer to the 1965 act as a "hoax on the American people" (U.S. House of Representatives 1969, p. 267, citing Dr. Terry).

This dissonance between legislative intent and legislative action was detectable, in more than one sense, in the smoke-filled congressional hearings at the time. In 1967, for example, when Dr. Paul Kotin, director of the Division of Environmental Health Sciences, National Institutes of Health, came to testify about the health hazards of cigarette smoking, Senator Norris Cotton (R-NH) asked, "Is it going to prejudice anybody if I smoke my pipe?" Dr. Kotin replied, "I trust it won't prejudice anybody any more than my smoking my pipe will" (U.S. Senate 1968, p. 14). Dr. Kotin's smoking was a topic of conversation again in congressional hearings in 1969. Dr. Kotin along with Surgeon General William H. Stewart, Dr. Kenneth Milo Endicott (director of the National Cancer Institute), and Dr. Daniel Horn (director of the National Clearinghouse on Smoking and Health) came together to testify in favor of stronger health warnings on cigarette packages and legislation requiring similar warnings in all cigarette advertising. At one point, Representative Dan H. Kuykendall (R-TN) asked Surgeon General Stewart, "Isn't [Dr. Kotin] one of the most knowledgeable men in this field?" When the Surgeon General replied affirmatively, Kuykendall returned, "Why doesn't he quit smoking?" Kuykendall then directly asked Kotin whether he was sure that smoking a pipe did not cause lip cancer; Kotin responded, "A risk I am willing to take, sir" (U.S. House of Representatives 1969, p. 167). The next day, Representative Tim Lee Carter (R-KY) observed that, in fact, all four of the men in the delegation, including the Surgeon

General, were smokers (U.S. House of Representatives 1969). Actions undermine words, and scenes such as these were symbolic of a strong wish not to believe in the health consequences of smoking. Given that the nation's chief health policymakers did not, or were not able to, apply to their own behaviors the very evidence they had gathered, the strength with which the smoking norm persisted among the general population is more easily comprehended.

Economic and Social Impedance

General economic conditions also supported the continuation of smoking. The 1960s and early 1970s was a time of general prosperity. Real cigarette prices rose in the 1960s but declined in the 1970s (USDHHS 1994). The affordability of cigarettes increased from 1965 to 1980 and served as an economic counterweight to the growing awareness of tobacco's ill effects (Lynch and Bonnie 1994) (see also "Effect of Price on Demand for Tobacco Products" and "Taxation of Tobacco Products" in Chapter 6).

Another compelling social condition may have further limited the initial impact of the Surgeon General's report. From the early 1960s to 1973, American military personnel were engaged in Vietnam. During this period, 8.7 million Americans served in the military, including 2.7 million in Vietnam (Moss 1990). Whether the Vietnam War encouraged smoking has not been a topic of speculation, probably because of that war's more publicized role in supposedly encouraging the use of marijuana and other drugs (Klein 1993). But the norm of smoking would only have been strengthened by the mobilization of a large military force bringing several million young men and women into a setting where smoking was traditionally held to offer relief from both stress and boredom, and where it was part of a lingering cultural image of the heroic soldier. Moreover, the prevalence of cigarette smoking was and has remained higher in the military than in the population at large (in 1992, 35 vs. 26 percent) (Lynch and Bonnie 1994).

Delayed Effects and Delayed Actions

A significant biologic explanation for the delayed effect of the 1964 report can be found in the delayed progression of smoking-related diseases, which generally take substantial time to fully manifest themselves in chronic illness and death. The cigarette's tremendous growth in popularity during the decades preceding the Surgeon General's report would thus

have only begun to show its vast health consequences. In 1965, an estimated 180,000 persons died from smoking-related diseases (USDHHS 1989); over the next two decades, that yearly estimate increased to 337,000, even though smoking prevalence had been steadily declining since the early 1970s (USDHHS 1989). First-time or long-time smokers in the mid-1960s to mid-1970s thus had far less opportunity than the next generation to personally witness the tragic but convincing demonstration of the health consequences of smoking. It might be hypothesized that this somber proof of the Surgeon General's report at last evoked a meaningful response among the surviving relatives and friends of the deceased.

From Disease Treatment to Risk Management

Another possible reason for the delayed response to the Surgeon General's report was its less-than-traditional medical perspective. The report's medical researchers were reporting not the kind of traditional clinical data that physicians were used to encountering in their literature but rather data from epidemiologic studies that indicated the risks of smoking. Eventually, such data would be persuasive enough to mark a perceptual shift to "a new kind of numeracy among medical researchers and clinicians alike" (Burnham 1989, p. 19). But in 1964, most physicians were not prepared to understand—much less be persuaded by—the epidemiologic data represented in the report, nor to incorporate a public health model into their medical practice.

Accordingly, the medical profession did not quickly jump on the smoking reduction bandwagon that began rolling with the Surgeon General's report. The American Medical Association Alliance House of Delegates, in fact, refused to endorse the report when it appeared in 1964 (Burnham 1989). Medical personnel increasingly warned people against smoking, but this precept did not carry over into practice. In 1964, smoking remained as acceptable in medical settings as it was elsewhere. Moreover, although 95 percent of physicians in that year saw smoking as hazardous, 25 percent continued to smoke (Burnham 1989); even by the mid-1970s, nearly one in five physicians was a smoker (Nelson et al. 1994). The AMA was criticized by other health organizations for not taking a more aggressive stance to reduce tobacco use. As late as 1982, for example, the association was faulted for helping prepare for *Newsweek* a 16-page "personal health care" supplement, in which the only advice provided

on smoking was that a smoker should discuss the risks with a personal physician and should refrain from smoking in bed (Iglehart 1984). Soon thereafter, the AMA had become an active advocate (see "Toward a National Policy to Reduce Smoking," later in this chapter). By 1990–1991, only 3.3 percent of physicians smoked, although smoking rates among nurses were significantly higher (Nelson et al. 1994).

Some social critics of the time tacitly welcomed what they saw as a rare reluctance by the establishment to embrace a social movement. Sociologists and other outside observers of American medicine had noted a previous tendency of the establishment to "medicalize" social problems, such as tobacco use and alcohol abuse. From this perspective, medicine was viewed askance as an "institution of social control," as a "new repository of truth, the place where absolute and often final judgments are made by supposedly morally neutral and objective experts" (Zola 1972, p. 487). Implicit in this criticism was the fear that the medical establishment was using its considerable clout—its professional domination of the world of facts—to translate all social ills into clinical terms that could be treated in a clinical setting. One such critic, medical sociologist Eliot Freidson, wrote that the physician who calls alcoholism a disease "is as much a moral entrepreneur as a fundamentalist who claims it is a sin" (Freidson 1974, p. 253).

But the medical establishment's initial hesitancy to join the movement to reduce smoking likely had little to do with scruples about overstepping its purview. There is no dispute that cancer is a disease and little dispute that the medical profession is the expert social authority for defining and treating it. The "moral entrepreneurship" of the Surgeon General's 1964 report was not to declare cancer a medical problem but rather to declare smoking a health risk—hence the central position of epidemiologic data in the report.

Thus, while organized medicine followed slowly and sometimes reluctantly in the wake, and while social skeptics worried about the Orwellian implications, a battery of public health officials, politicians, and consumer advocates, armed with the findings of the Surgeon General's report, moved against the persisting social and medical problem of smoking. Ultimately, the broad cultural current that distrusted medical moral entrepreneurship embraced these efforts. The "demedicalizing" movement, which sought to make health care both a personal matter and a political matter rather than one wholly under the guardianship of physicians (Starr 1982), supported a practice of medicine that took a preventive stance instead of an exclusively therapeutic one. Preventive action—to prevent smoking, and

thereby to prevent unnecessary illness and death from smoking-related illnesses—was precisely the solution

called for in the epidemiologically based recommendations of the 1964 Surgeon General's report.

The Diverse Momentum of the Movement to Reduce Smoking

Another reason for the languid pace of change in smoking prevalence after 1964 is that it took time to assemble an active dissemination and lobbying force around the Surgeon General's report. In the present period, so many different groups are active in anti-smoking activity, and so many different strategies are operating, that sorting them becomes difficult. Since 1964, the campaign to reduce smoking refers to "the entirety of changes in the social environment spawned by scientific and social interest in the hazards of smoking" (Warner 1989, p. 144); this movement covers not only specific activities but also "the changing social norms that have accompanied them" (p. 144). The span of activities involves persons, private organizations, and government agencies, all with different motivations: those ideologically committed to a movement to reduce smoking, those who operate profit-making businesses, those seeking public office, and those in public office who mandate laws and regulations. Important actors have included national health organizations, medical researchers, organized medicine, government regulatory agencies and health departments, school officials, voluntary organizations in health, lobbying groups for reducing smoking, private firms dealing with the health or insurance needs of employees, smoking cessation clinics, and individual medical practitioners.

The industry-funded Tobacco Institute began distributing smoking education materials in 1984 (USDHHS 1994), although with a different agenda. For example, the institute's "It's the Law" program purports to discourage minors from purchasing cigarettes (Tobacco Institute 1990), but the program focuses on the legal responsibilities of the purchaser rather than the vendor, characterizes smoking as an "adult behavior" (which may make it more attractive to adolescents), does not address the dangers of smoking, and, in one assessment, was ineffective in preventing illegal sales (DiFranza et al. 1996).

The work of the Tobacco Institute highlights what may be the foremost obstacle to changing the social norm of smoking: the multifaceted actions of the

industry in preventing prevention. In an analysis of tobacco industry tactics, the Advocacy Institute (1995) has defined nine areas of activity: intimidation, alliances, front groups, campaign funding, lobbying, legislative action, buying expertise, philanthropy, and advertising and public relations (see the text box). In its discussion of well over 100 instances in these areas, documented largely from media reports, the Advocacy Institute does not accuse the tobacco industry of illegal activity but rather of a far-ranging and systematic effort to ensure the continued use of tobacco. Taken together, and backed by the enormous resources of the industry, these efforts have considerable impact in promoting tobacco use and retarding efforts to reduce or prevent it. Because of the considerable litigation now directed at the industry, however (see Chapter 5), the public is more aware of these efforts and may prove more resistant than previously to this powerful commercial subterfuge.

Support From Business

The supportive role of businesses in the movement to reduce smoking probably did not arise from a spontaneous realization that preventive measures could improve employee health. Already shouldering new costs from complying with health-related (but non-tobacco-related) new federal legislation, such as the Occupational Safety and Health Act of 1970 (Public Law 91-596) and the Toxic Substances Control Act (1976) (Public Law 94-469), many companies in the 1970s sought ways to control the rapidly rising costs of health care (Iglehart 1982). Supporting or enacting policies to curb a proven health risk (such as smoking) that had expensive consequences simply made good business sense.

A special case is insurance. Beginning with State Mutual Life Assurance Company of America in 1964, life insurance companies began offering discounted policies for nonsmokers (Cowell 1985). By 1987, approximately 80 percent of life insurance companies offered discounts to nonsmokers (Schaufler 1993).

Framework of Tobacco Industry Tactics

The Advocacy Institute has developed an overview of tobacco industry strategy, with extensive documentation taken from current media reporting. The documentation provides examples of each of the strategies listed below.

- I. Intimidation
 - A. Legal (harassing suits, subpoenas, injunctions, outspending plaintiffs)
 - B. Economic (withdrawal of advertising, withdrawal of business operations)
 - C. Political (retribution directed at elected and other officials)
 - D. Personal (harassing researchers, advocates, and reporters)
- II. Alliances
 - A. Strong allies (subsidiaries, trade associations, advertising industry, tobacco farmers)
 - B. Weak allies (labor unions, lawyers' associations, doctors' associations)
- III. Front Groups
 - A. Political groups (Michigan Citizens for Fair Taxes, Californians for Statewide Smoking Restrictions)
 - B. Scientific groups (Council for Tobacco Research U.S.A. Inc., Healthy Buildings International)
 - C. Smokers' rights groups (National Smokers Alliance)
- IV. Campaign Funding
 - A. Candidate funding
 - B. Continued contributions after election
 - C. Direct funding of interest groups and caucuses
 - D. Political party funding
 - E. Funding state ballot initiatives, or funding opposition to initiatives
- V. Lobbying
 - A. Support of lobbyists at state and national levels
 - B. Seeking alliances with other lobbying groups on specific issues
 - C. Gifts and contributions to specific causes
 - D. Generating grassroots activity
- VI. Legislative Action
 - A. Preemption
 - B. Weakening or diluting legislation, or making it unenforceable
 - C. Adding unrelated clauses to, or changing, the contents of legislative bills
 - D. Shifting debate (stressing personal freedom rather than health; promoting smokers' rights)
- VII. Buying Expertise
 - A. Enlisting outside experts (economists, epidemiologists, medical researchers, statisticians, legal counsel)
 - B. Creating the Council for Tobacco Research U.S.A. Inc.
- VIII. Philanthropy
 - A. Buying innocence by association (financial support to wide range of organizations)
 - B. Funding (women's groups, racial and ethnic minority groups, homeless shelters, acquired immunodeficiency syndrome [AIDS] groups, arts groups, educational initiatives, community-based nonprofit organizations, sporting events)
- IX. Advertising and Public Relations
 - A. Issue framing (choice, civil rights, personal freedom)
 - B. Advertising to promote corporate character
 - C. Disinformation (health effects, economic importance of tobacco)

Source: Advocacy Institute 1995

Health insurance rates, in contrast, have not typically distinguished between smokers and nonsmokers. Acceptable actuarial data on additional medical expenses incurred by smokers did not exist until the early 1980s; at present, discounts for nonsmokers or surcharges for smokers have not been widely adopted by health insurance companies (Schauffler 1993). Nonetheless, both the health insurance and the life insurance industries have become active in smoking-related public policy. In 1977, the trade associations of the two industries formed the Center for Corporate Public Involvement to take up public policy issues that affected them. By 1980, the organization was urging its members to adopt workplace nonsmoking policies, and by 1984, it had become an active lobbyist supporting legislation to reduce tobacco use (Schauffler 1993).

The Attack on Advertising

In the 1970s and 1980s, the movement to reduce smoking was in part the work of grassroots activity, in part the work of professional consumer advocates, and in part the work of the public health bureaucracy. In 1966, a complaint filed with the Federal Communications Commission (FCC) by John F. Banzhaf III called for the application of the Fairness Doctrine to mandate reply time to cigarette advertising on television and radio broadcasts (see also "Attempts to Regulate Tobacco Advertising and Packaging" in Chapter 5). The FCC agreed with Banzhaf's complaint and on June 2, 1967, ordered broadcasters to provide "significant" air time for antismoking messages. Banzhaf, anticipating and forestalling an almost certain appeal from the tobacco industry, appealed his own victory (Whiteside 1971). Under the guise of seeking equal rather than significant broadcast time, Banzhaf succeeded in having his original ruling upheld and in having its application specified: television and radio stations were required to run one counter-advertisement, free of charge, for every three cigarette commercials. This policy lasted until 1971, when a ban on cigarette broadcast advertising went into effect.

The campaign to ban or regulate cigarette advertising has been one of the most visible and emotionally compelling of all the subthemes in the campaign to reduce smoking. (Highlighted in this section, this theme is discussed in greater detail in "Attempts to Regulate Tobacco Advertising and Packaging" in Chapter 5.) All along, opponents have apparently "resented most of all the ubiquity and presumed power of cigarette advertising" (Patterson 1987, p. 224). These critics have argued that advertising is a powerful force blinding Americans to the health consequences of

smoking, but the tobacco industry has maintained a vigorous defense of its right to advertise (Patterson 1987).

In 1969, congressional hearings considered banning cigarette advertising on television and radio; strengthening health warnings on packages; extending the warnings to all cigarette advertising; and ending the preemptive ban on FTC, state, and local regulatory activity. This time, the tobacco industry did not benefit, as they had during hearings in previous years, from the hesitancy of those conducting the hearings. Since 1964, public concern about the health hazards of smoking had been growing, and although the tobacco industry had powerful supporters in the U.S. House of Representatives, in the Senate, Warren Grant Magnuson (D-WA) and Frank E. Moss (D-UT) were canny and committed antagonists. Recognizing it would have to make some concessions, the industry agreed to a television and radio advertising ban.

This concession may not have been unwilling. There is some indication that since the Fairness Doctrine was invoked in 1966, the resulting counter-advertisements were hurting cigarette sales more than the cigarette commercials were helping (Hamilton 1972). With the passage in 1969 of the Public Health Cigarette Smoking Act (Public Law 91-222), which contained the ban on cigarette advertising on television and radio, the counteradvertisements vanished. The tobacco industry shifted its advertising to print and, perhaps even more notable, shifted its marketing budget from advertising toward promotion. The latter move exposed vast audiences to cigarette brands through techniques such as sponsoring sports events and, later, merchandising brand-touting items such as T-shirts and caps. Nonetheless, the elimination of cigarette advertising from the nation's most powerful medium was at the very least a stunning symbolic defeat for the tobacco industry. At the same time, the presence of cigarettes was gradually fading in television programming; by 1982, fictional television characters smoked nine times fewer cigarettes than they had before 1964 (Signorielli 1993).

Toward a National Policy to Reduce Smoking

Victories through federal administrative agencies or through direct assault on Congress were rare. The first chairman of the new (1973) Consumer Product Safety Commission claimed authority to set standards for cigarettes or even to ban them, but Congress in 1976 passed legislation to deny the commission that

authority (Walsh and Gordon 1986). In 1972, the Civil Aeronautics Board required a nonsmoking section on commercial air flights, in part because of some voluntary action already taken; in 1983, responding to a Court of Appeals ruling that nonsmokers were inadequately protected, the board banned smoking altogether on flight segments up to two hours—but almost at once Congress passed legislation to reverse this move (Walsh and Gordon 1986).

In the executive branch, several voices spoke out against smoking. During his tenure as Surgeon General and thereafter, Dr. Jesse L. Steinfeld was an active participant in the national and international movement to reduce smoking (Steinfeld et al. 1976). Joseph A. Califano, President Jimmy Carter's Secretary of Health, Education, and Welfare, declared in 1978 that smoking was "Public Health Enemy Number One." When Califano was designated Secretary, he had no notion that reducing smoking should be a significant effort of the Secretary's department, but experts he

consulted invariably urged that his public health efforts include a major campaign on that topic (Califano 1981).

Over the years, the main voluntary organizations increased their aggressive posture against smoking. In 1982, the ACS, the ALA, and the AHA established the jointly sponsored Coalition on Smoking OR Health as a Washington-based lobbying organization. The coalition represented some 5 million volunteers across the country, at least some of whom were physicians and other civic leaders who could influence particular legislators (Pertschuk 1986). In 1985, the AMA called for a complete ban on tobacco advertising and promotion (Troyer 1989). Also that year, a rotating series of four more specific, more severe, and larger print warning labels replaced the traditional warning that "The Surgeon General has determined that cigarette smoking is dangerous to your health" (Waxman 1985; see "Attempts to Regulate Tobacco Advertising and Packaging" in Chapter 5 for discussion of this regulatory process).

From Antismoking to Nonsmokers' Rights

The rhetoric of the smoking controversy in the 1950s and 1960s focused on the scientific evidence linking smoking and disease. In the wake of the 1964 Surgeon General's report and subsequent research and reports, the battle over the credibility of the scientific evidence was essentially over. In what has been called "a remarkable demonstration of creative lobbying" (Jacobson et al. 1992, p. 39), the tobacco industry sought to shift the debate from the medical consequences of smoking to the legal implications of impeding the personal freedom of smokers to smoke and of tobacco companies to advertise their wares under the protection of the First Amendment. The tactic appeared to work. By the late 1970s, the effort to reduce smoking was foundering "on a traditional American libertarian ethic: 'It's my body and I'll do with it as I please'" (Brandt 1990, p. 167). Serious discussion on the ethics of legislation to reduce smoking emerged (Goodin 1989). To bring a public health perspective back into the center of the debate, a countershift to nonsmokers' rights seemed strategically sound (Jacobson et al. 1992). During the 1980s, this strategy acquired a conceptual foundation that was framed in a persuasive vocabulary when the

terms (and the concerns they aroused) "passive smoking," "ambient smoke," "secondhand smoke," and most commonly, "environmental tobacco smoke" (ETS) increasingly appeared in research reports and public debate.

Regulations, Legislation, and Lobbying for Nonsmokers

Evidence mounted in the 1970s and 1980s that smoking was not only an annoyance but also a health hazard to nonsmokers. The 1972 Surgeon General's report on smoking and health became the first of the series to include a review of the effects of ETS. A year earlier, Surgeon General Steinfeld had called for a national "Bill of Rights for the Non-Smoker." The call was answered when the National Interagency Council on Smoking and Health developed a Non-Smoker's Bill of Rights and promoted the nonsmokers' rights theme among its 34 member agencies (Schmidt 1975). At the same time, the first successful efforts were made to segregate smokers and nonsmokers in public places. In 1971, United Air Lines became the first

major carrier to institute separated "smoking" and "nonsmoking" sections on its airplanes.

Analogous to private citizens who were active in the antismoking movement early on, some private businesses took the initiative to introduce worksite regulations for reducing smoking. Typically, the private firms would begin with a mild antismoking policy that was made stricter over time. A life insurance company in Connecticut, for instance, in 1976 restricted smoking in parts of the employee cafeteria. In 1983, smoking was prohibited throughout the cafeteria and was also banned from all conference rooms. In 1986, all smoking at the workplace was prohibited except in designated restrooms and lounges. Moreover, the company instituted an educational campaign about smoking hazards and provided subsidies for employees who attended smoking cessation clinics (Petersen et al. 1988). Other firms have also turned to carrots as well as sticks, paying employees bonuses if they stop smoking for a given length of time (Fielding 1984).

States began advancing legislation against ETS in the early 1970s. In 1973, Arizona passed the first statewide ban on smoking in public places. This important step for nonsmokers' rights, which was initiated by a private citizen, Betty Carnes, was defeated in a vote in 1972 but passed on its second try and a year later was further strengthened (Schmidt 1975). Two years later, Minnesota passed the first statewide act to keep indoor air smoke free; the legislation required no-smoking areas in all buildings open to the public unless a posted sign explicitly permitted smoking. By 1975, legislation had passed in 10 states to regulate smoking in public places (Schmidt 1975); more than 30 states and hundreds of local jurisdictions had done so by 1985 (Koop 1985). By 1990, smoking was restricted to some extent in public places or worksites in 44 states, and hundreds of cities and towns had passed their own, often more rigorous ordinances (Rigotti and Pashos 1991). In cities with populations of 25,000 or more, local smoking restrictions reached more than two-thirds of citizens in various public and private settings, and one-half of these restrictions could be judged comprehensive.

The courts supported these public and private efforts to protect nonsmokers' rights. In 1976, a Superior Court of New Jersey ruled that an office worker with an allergy to tobacco smoke had the right to a smoke-free office. New Jersey was also the site of a comprehensive ruling in 1978 that restricted smoking in restaurants and other public places; this was the first such regulation to be enacted by administrative rule (through the State of New Jersey Department of Health) rather than by new legislation, though the rule

was never actually implemented (Regina Carlson, memorandum to John Slade, September 30, 1996).

At the federal level, government acted not only legislatively to regulate public behavior in the states but also administratively to regulate domains the government itself directly controlled. For instance, cigarettes were removed from military C rations and K rations in 1975, and smoking was restricted in all federal government buildings in 1979. Smoking was banned in the White House in 1993 (Stephanopoulos 1993).

Behind many of these reforms in industry and government were the unified efforts of private citizens. How these grassroots activists could band together to form powerful lobbying groups for nonsmokers' rights was shown in the transformation of a segment of the Group Against Smokers' Pollution (GASP), Inc., a national organization founded in 1971. In 1976, local California chapters of GASP banded together and tried but failed to effect statewide ordinances to protect nonsmokers. In 1981, the chapters became Californians for Nonsmokers' Rights and began focusing on local legislative activity. Five years later, the group became a national organization that took its successful local-level approach to sites throughout the country. By 1986, more than 75 ordinances had been enacted in California alone; nationwide, more than 400 had been enacted by 1990 (Samuels and Glantz 1991). In 1985, Los Angeles banned smoking in most public places and in businesses employing four or more persons if nonsmokers requested it (Fritschler 1989). California has now banned smoking in practically all public places (Tobacco Education and Research Oversight Committee 1995).

By the 1980s, the movement to reduce smoking proceeded along many avenues and through a wide set of loosely coordinated organizations. This lack of systematic action has concerned activists in the movement, who bemoan duplication of effort, lack of communication, organizational rivalries, and the lack of a federal effort and policy. At the same time, the movement has clearly benefited from its multiple locations; the movement is represented by active legislative efforts in hundreds of small communities as well as by a strong presence in Washington, DC, and in state capitals (see also "Direct Advocacy" in Chapter 7 for a discussion of the influences of these advocacy activities).

ETS: From Annoyance to Carcinogen

The powerful call for nonsmokers' rights added considerable momentum to the campaign to reduce smoking. The Surgeon General's report in 1979

reviewed further research on ETS. Considerable public interest was aroused by a Japanese study, published early in 1981, that found a high incidence of lung cancer among nonsmoking women married to smoking men (Hirayama 1981; *Newsweek* 1981). While local-level smoking restrictions began to gather force, often proving more comprehensive than statewide legislation, the evidence on passive smoking accumulated. On releasing his 1982 report on smoking and health, Surgeon General C. Everett Koop observed that ETS might be a serious public health problem (Troyer 1989); two years later, he spoke of solid evidence on this point (quoted in Molotsky 1984, p. 1).

The growing urgency of a public health focus on ETS set the stage for two authoritative messages that ETS posed a definite danger to all. In 1986, the National Research Council report *Environmental Tobacco Smoke: Measuring Exposures and Assessing Health Effects* found that ETS exposure increased the risk for lung cancer by 30 percent in nonsmokers and had deleterious effects on the respiratory health of children (National Research Council 1986). The same year, the Surgeon General released *The Health Consequences of Involuntary Smoking*, which concluded that "involuntary smoking is a cause of disease, including lung cancer, in healthy nonsmokers" (USDHHS 1986, p. 13). That report also found that children of smoking parents have an increased incidence of respiratory infections and that separating smokers and nonsmokers

within the same air space "may reduce, but does not eliminate" exposure of nonsmokers to tobacco smoke (p. 13).

Critics charged that the evidence on passive smoking was weak, but the evidence and the authoritative conclusions of the Surgeon General and the National Academy of Sciences added support for stronger acts to limit or prohibit smoking indoors. In 1987, Congress banned smoking on domestic air trips shorter than two hours; in 1990, the ban was effectively extended to all domestic commercial air travel.

Two further developments raised public (and public policy) awareness of ETS to a level that positioned it in the front ranks of the campaign to reduce smoking. In 1991, the National Institute for Occupational Safety and Health, Centers for Disease Control, issued the report *Environmental Tobacco Smoke in the Workplace*, which concluded that ETS can cause lung cancer and other health problems (National Institute for Occupational Safety and Health 1991). More important, in December 1992, the Environmental Protection Agency (EPA) classified ETS as a "Class A" carcinogen, the most dangerous class of carcinogens. The agency's final report, *Respiratory Health Effects of Passive Smoking: Lung Cancer and Other Disorders*, concluded that ETS is a human lung carcinogen responsible for some 3,000 deaths annually from lung cancer among nonsmokers (EPA 1992).

The Impact of the Movement to Reduce Smoking

The campaign against tobacco promotion is, in a sense, a public health hybrid. It is in part a public health movement, like those oriented to ensure that food and drugs are pure and that water supplies and air quality are clean—movements that look to improve upon the collective provision of healthful environments. But because the campaign to reduce smoking necessarily seeks to alter personal behavior, it is perceived or cast by some as a moral reform movement. "We are in the midst of one of those periodic moments of repression," writes one observer, "when the culture, descended from Puritans, imposes its hysterical visions and enforces its guilty constraints on society, legislating moral judgments under the guise of public health, all the while enlarging the power of surveillance and

the reach of censorship to achieve a general restriction of freedom" (Klein 1993, p. 3). Such critics worry about possible erosions of civil liberties and express irritation with the puritanical cast of the movement to reduce smoking (Berger 1986; Hitchens 1994; Leonard 1994; Laqueur 1995). One recent historian refers to health reform movements of this and the past century as "hygienic ideologies," because the movements have sometimes reached levels of "devotion, asceticism, and zeal" that virtually mark them as "hygienic religion" (Whorton 1982, p. 4). In sum, the arguments have pitted this moralism against the freedom to choose (Sullum 1996). In doing so, issues of addiction and corporate responsibility are sidestepped (Hilts and Collins 1995).

It would be hard to deny that moral zealotry has entered into the contemporary movement to reduce smoking. But it would be equally hard to argue that zealotry is the dominant element in the movement. The contemporary campaign to reduce smoking, like some elements of the early 20th-century efforts, has been fueled by medical research and, more recently, by revelations about the additional but secret medical research carried on by tobacco companies themselves on nicotine and other addictive substances (Kluger 1996). But leadership has been both medical and non-medical and has been oriented to conventional public policy mechanisms rather than to moral reformation. Where the broad contemporary health movement has “an ambivalent orientation toward science and technology” and “draws upon Americans’ significant and growing distrust of physicians” (Goldstein 1992, pp. 30–1), the movement to reduce smoking firmly embraces establishment medical research. Its sometimes inventive and ingenious strategies notwithstanding, the movement has typically avoided ideological ends and has instead worked toward concrete, public policy objectives. In this respect, it is self-consciously political, adopting a style found now in many health movements (e.g., AIDS, breast cancer, and even advocates of specific health care reforms).

Whether or not the movement to reduce smoking has avoided the finger-pointing associated with many ideological movements is debatable. On the one hand, the movement has tended to demonize the tobacco companies rather than the smokers who use their products. This distinction may arise partly because, some cultural icons aside, smoking has rarely been perceived as a feature of personal behavior that is central to someone’s identity. Placing the burden elsewhere than on the smoker has been amply reinforced by the research-steered perceptual transition of smoking as “habit” to smoking as “addiction.” As codified by the 1988 Surgeon General’s report (USDHHS 1988) and reiterated more recently (Lynch and Bonnie 1994), smoking is now medically viewed as nicotine addiction, and as the title for Chapter 4 states, smoking cessation is now the management of such addiction. This transition has had considerable impact on overall strategy for reducing smoking, especially in litigation approaches (see “Litigation Approaches” in Chapter 5).

On the other hand, as regulations against smoking become more widespread, the tendency to stigmatize smokers may increase (Troyer 1989). Moreover, some critics have complained of an ideology that smacks of political conservatism, in that the focus for the problem is turned away from the product source

(the manufacturer) and to the user-victim (the smoker); this blame-the-victim perspective also characterizes sociopolitical movements that divert public attention to personal behaviors and away from larger, corporate sources of environmental health risks, such as industrial pollution and workplace hazards (Crawford 1979).

In at least one sense—that of social values—efforts to reduce smoking have been moralistic. The contemporary reform movement can fairly be characterized as middle-class—that is, its values are those connected with traditional values such as deferred gratification, self-control, and personal responsibility (Goldstein 1992). Nonsmokers may feel morally superior to smokers, and former smokers may pride themselves on their personal accomplishment and self-denial. As one cultural observer has pointed out, former smokers especially may be “tediously zealous about the addiction they have left behind” (Styron 1987, p. 284).

The net result, whatever the role of moral issues, is the main emphasis the movement places on changing the social conditions that enable, and the cultural conditions that legitimize or romanticize, smoking. In this sense, the movement to reduce smoking is an old-fashioned populist movement that seeks to defend the “public interest” against the moneyed corporations, the purveyors of death and disease. It is now less an “anti-smoking” political movement and more a campaign against tobacco promotion.

A reflection of this broadly populist attitude has been the movement’s lack of any real links to partisan politics. Senators Wallace F. Bennett (R-UT) and Richard L. Neuberger (D-OR) were among the first to seek curbs on the tobacco industry (Fritschler 1989). In the early 1980s, Republican Senators Robert W. Packwood (R-OR) and Orrin G. Hatch (R-UT) introduced legislation to require more explicit warning labels on cigarette packages (Troyer 1989). House Democrats have been both key defenders and key critics of the tobacco industry. In the White House, Democratic President Lyndon B. Johnson remained silent on the preemptive Federal Cigarette Labeling and Advertising Act of 1965, but White House pressure helped support the Tobacco Institute’s efforts to pass the bill (Pertschuk 1986); the President signed the act into law privately in his office, without guests or comment (Fritschler 1989). Similarly, Democratic President Jimmy Carter refused to take a position on tobacco (Fritschler 1989), but he regarded USDHEW Secretary Joseph Califano’s crusade against tobacco as “an enormous political liability” (Califano 1985, p. 360). The absence of political affiliation for the antitobacco movement may be

altered, however, by recent changes in the party composition of elected officials from tobacco-producing states.

The efficacy of efforts to reduce smoking, independent of other social changes beginning early in the 20th century, is hard to determine. Students of 19th-century temperance, for example, have concluded that although the temperance efforts likely accelerated the antebellum decline in alcohol consumption, the decline may have been more deeply tied to independent changes in styles of liquor consumption (Aaron and Musto 1981). The antismoking movement of the early 20th century, despite temporary gains, had little long-term effect on stopping the rapid growth of smoking; though noteworthy, the emergence of antismoking legislation in some midwestern and western states was brief and showed little convincing evidence of enforcement.

But neither the temperance movement of the 19th century nor the antismoking movement early in the 20th century commanded the significant allies and the range of weapons of the contemporary effort to reduce smoking. The critical factor has been definitive medical research linking smoking to cancer, heart disease, chronic obstructive pulmonary disease, and adverse outcomes of pregnancy (USDHHS 1989). Beginning in 1964, the imprimatur of the Surgeon General of the United States provided a symbolic centerpiece that has given inestimable momentum to the campaign. The all-but-unanimous and compelling character of the epidemiologic research in that first report and its successors is the chief factor that leads to the conclusion, "As a target of opportunity for public health action, smoking stands alone" (Walsh and Gordon 1986, p. 127).

Measuring the overall impact of the rich and multifaceted effort to reduce smoking is difficult, in part because current prevalence should not be judged against an arbitrary historical benchmark (for instance, against prevalence at the time of the 1964 Surgeon General's report) but against an estimate of what prevalence would have been in the absence of such efforts. The events of the past decades that coincided with these efforts are clear: cigarette consumption rose steadily from the 1930s until 1963, fluctuated, then fell from 1973 to the present. But such broad-brush observations provide little insight into cause and effect, especially given the multiplier effect of certain social actions, the differential changes in demographic and social subgroups, and the influence of forces extraneous to smoking (Warner 1989).

It is problematic, for example, to try to assess the relative impact of, on the one hand, government educational actions and government regulatory actions and, on the other hand, changing social norms—two factors that are clearly interrelated. The impact of government curbs on smoking in public places (see "Clean Indoor Air Regulation" in Chapter 5) may actually be bound up with "voluntary adjustments to new information" (Zimring 1993, p. 97). Similarly, doubts have been raised as to the influence of curbs on tobacco advertising (Schudson 1993; see "Advertising and Promotion" in Chapter 5), because such restrictions have occurred in conjunction with a growing stigmatization of smoking. Once nonsmoking is established as a norm, the minority status of smokers makes them "more vulnerable to negative social evaluations. . . . 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" (Zimring 1993, p. 106). Such a reinforcing chain of events may permit curbs on advertising, rather than the reverse.

It is equally difficult to gauge or predict the influence of government restrictions. On the one hand, a regulation may be an educative force—for example, by reminding people to take their Surgeon General seriously. In some instances (such as indoor prohibitions and access restrictions), government actions interpose a physical barrier. On the other hand, legal or otherwise formal barriers could have an unintended effect on individual predisposition, as the abiding aura of antisocial behavior can be at least as great a stimulus for some as it is a deterrent for others. Finally, the psychological and social pathways by which economic actions of government affect smoking are complex.

Sorting through this complexity is critical to understanding appropriate policy and action for reducing smoking. The ensuing chapters assess the available evidence to judge the efficacy of educational efforts (Chapter 3), the management of nicotine addiction (Chapter 4), regulatory efforts (Chapter 5), economic approaches (Chapter 6), and comprehensive programs (Chapter 7). This brief history of the anti-smoking movement provides a backdrop to such assessment and may furnish some perspective on future directions.

Conclusions

1. In the years preceding the development of the modern cigarette, and for some time thereafter, antismoking activity was largely motivated by moralistic and hygienic concerns. Health concerns played a lesser role.
2. In contrast, in the second half of the 20th century, the impetus for reducing tobacco use was largely medical and social. The resulting platform has been a more secure one for efforts to reduce smoking.
3. Despite the growing scientific evidence for adverse health effects, smoking norms and habits have yielded slowly and incompletely. The reasons are complex but attributable in part to the industry's continuing stimulus to consumption.

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