Ethical Concerns in Tobacco Control

Nonsmoker and "Nonnicotine" Hiring Policies: The Implications of Employment Restrictions for Tobacco Control

| Kristin Voigt, DPhil

Smoking has been restricted in workplaces for some time. A number of organizations with health promotion or tobacco control goals have taken the further step of implementing employment restrictions. These restrictions apply to smokers and, in some cases, to anyone testing positive on cotinine tests, which also capture users of nicotine-replacement therapy and those exposed to secondhand smoke.

Such policies are defended as closely related to broader antismoking goals: first, only nonsmokers can be role models and advocates for tobacco control; second, nonsmoker and "nonnicotine" hiring policies help denormalize tobacco use, thus advancing a central aspect of tobacco control.

However, these arguments are problematic: not only can hiring restrictions come into conflict with broader antismoking goals, but they also raise significant problems of their own. (*Am J Public Health.* 2012; 102:2013–2018. doi:10.2105/AJPH.2012.300745)

RESTRICTIONS ON SMOKING IN the workplace have become common in many parts of the world. More recently, however, a number of organizations have taken the further step of implementing nonsmoker hiring policies that bar tobacco users from employment. Some hospitals have even put in place what they call "nonnicotine hiring policies," which exclude all job candidates who test positive on cotinine tests, including not only tobacco users but also those who use cessation aids containing nicotine or those who are exposed to secondhand smoke.

Although such policies do not violate employment legislation in many US states,[1,2] it does not follow that they are ethically permissible. Such hiring policies curtail, potentially severely, the employment opportunities of smokers and those who are exposed to nicotine for other reasons. They also raise concerns about social justice because smoking is more prevalent among lower socioeconomic groups who are also more vulnerable to unemployment and job insecurity. Although financial considerations are sometimes explicitly mentioned as motivators leading to the adoption of hiring restrictions,[3] hospitals and organizations whose objectives are linked to tobacco control have defended these policies as being crucial to their objectives: excluding job candidates who use tobacco or are exposed to nicotine helps ensure that employees can be role models and advocates in the fight against smoking; furthermore, these policies contribute to antitobacco efforts by further denormalizing tobacco use. If these arguments succeed, we may judge these benefits to outweigh the costs of such policies. However, I argue that these positions are inconsistent with other goals and concerns of the tobacco control community and may in fact run counter to the pursuit of antismoking goals.

FROM SMOKE-FREE TO SMOKER-FREE AND "NICOTINE-FREE"

Tobacco use has been identified as the world's leading cause of preventable death,[4] making tobacco control a central concern for public health. Along with a range of other tobacco control policies, restrictions on smoking in the workplace have been in place for some time in many parts of the world.[5] The arguments supporting such policies focus on protecting nonsmokers from the harmful effects of secondhand smoke.

However, a number of organizations have not only banned smoking from their premises, but have also implemented nonsmoker hiring policies that restrict the employment of tobacco users. Most prominently, the World Health Organization (WHO) introduced hiring restrictions in 2005, stating that it "does not recruit smokers or other tobacco users who do not indicate a willingness to stop smoking."[6] This policy is defended as closely connected to the organization's broader role in global tobacco control and its commitment to a tobacco-free environment.[6,7] Applicants for positions at the WHO must answer 2 questions on application forms: "Do you smoke or use tobacco products?" and "If you currently smoke or use tobacco products, would you continue to do so if employed by WHO?"[7] Applicants who answer yes to both questions will not be considered.[7] Current employees are generally exempt from such policies, although employers often emphasize that smokers on their staff are encouraged to quit and that cessation resources are on offer. However, those who are

found to have lied about their smoking status or their willingness to quit at the application stage may be subject to penalties: the WHO explains that such employees may be subject to "disciplinary action,"[7] and dismissal of employees who subsequently used tobacco has been reported at other organizations.[8,9]

Some US hospitals and health care organizations—including the Cleveland Clinic, Franciscan Health System in Washington, and Memorial Health Care System in Tennessee—have taken the additional step of denying employment not only to smokers but also to anyone who tests positive on a cotinine test. Other hospitals—including Baylor Health Care System in Texas and Geisinger Health System in Pennsylvania[10]—have adopted similar policies in recent months. A director of the Cleveland Clinic, which has received inquiries about how to introduce such policies, noted in 2011 that "the trend line is getting pretty steep" and that he expects "a lot of major hospitals" to take similar steps over the next few years.[9] In addition to hospitals, nicotine tests have also been introduced by agencies such as the Idaho Central District Health Department, and similar policies are being considered by Florida school officials.[11]

One important feature of cotinine tests is that they cannot distinguish between active tobacco use and exposure to nicotine through secondhand smoke or use of cessation aids that contain nicotine.[12] As one organization—Franciscan Health System—explains, "the test will pick up tobacco use from cigarettes, cigars, chew tobacco, nicotine patches and heavy

second-hand smoke. Only job applicants who pass will be considered for employment."[3] Accordingly, they describe their policy as a "nonnicotine hiring policy."[3]

In the remainder of this article, I use the terms "nonsmoker" and "nonnicotine hiring policy" to distinguish policies that aim to exclude active tobacco users from those that exclude anyone who tests positive on a cotinine test. It should be noted, however, that these terms are not used consistently in the debate. For example, the Cleveland Clinic, where job candidates are tested for cotinine, refers to its approach as a "nonsmoker" policy and does not address whether job candidates with positive results would be excluded from employment even if they are not active tobacco users.

THE ETHICAL COST OF EMPLOYMENT POLICIES

Nonsmoker and nonnicotine employment restrictions can have substantial implications for individuals. Some of the hospitals that have implemented them are major employers in their geographic areas. Even if applicants are "encouraged" to reapply once they have quit or their cotinine test is negative, there is, of course, no guarantee that a suitable position will still be available. Although it has been suggested that nonsmoker hiring policies could act as an "economic incentive"[13] for smokers to quit, not all smokers have the ability or resources to quit in response to such policies: we know that only a small fraction of cessation attempts are successful and that relapse is common.[14]

The move toward nonnicotine policies is particularly problematic. This move will affect those who are using nicotine-replacement therapy to assist quit attempts or to maintain abstinence. Furthermore, because they will also capture those exposed to secondhand smoke, such policies effectively punish individuals for the smoking behaviors of their families: short of leaving partners, parents, or children who smoke, this is something over which they have little, if any, control.

There is also a social justice dimension to these policies as smoking prevalence tends to be higher among lower socioeconomic status (SES) groups.[15–17] Commentators have worried, therefore, that such policies would pose a much greater problem for low-SES applicants than for those from higher-SES groups. At the University Medical Center in El Paso, TX, which stopped hiring smokers in October 2010, it was reported (in February 2011) that of the first 14 job candidates excluded from employment because they were tobacco users, 1 was a nurse and the remaining 13 were support staff.[9] This is, of course, only anecdotal evidence; furthermore, when nonsmoker or nonnicotine hiring policies are appropriately advertised, those who expect to test positive may simply refrain from applying.

Compared with their higher-SES peers, job candidates from lower socioeconomic backgrounds will also have less access to cessation resources and, on the whole, they will also be in a worse position when it comes to finding alternative jobs should they test

positive for cotinine. These policies could lead to further increases in unemployment among these groups, with all the negative effects—including health effects[18]—that this may entail. The full brunt of nonsmoker and nonnicotine hiring policies is therefore likely to be borne by those jobseekers who are already disadvantaged.

However, even if nonsmoker and nonnicotine hiring policies are unfair, this unfairness could be outweighed by the benefits such policies could provide. Given the health impact of smoking, we are often willing to accept tobacco control policies that can be seen as problematic in some respects, as long as such policies can lead to significant public health benefits. For example, despite concerns about regressivity, many countries maintain high levels of taxation on tobacco products, which is seen as a cost-effective way of reducing tobacco consumption, particularly among youths. This line of argument, however, is unlikely to be successful with respect to nonsmoker and nonnicotine hiring policies.

EMPLOYMENT RESTRICTIONS AND THE FIGHT AGAINST SMOKING

Organizations whose goals relate to health promotion and tobacco control defend nonsmoker and nonnicotine hiring policies as closely connected to the pursuit of such goals. Health care and tobacco control organizations have argued that, for them, such policies are integral to objectives of tobacco control and health promotion, and conducive to the

fight against smoking. Two arguments are put forward in support of such policies: first, employees of such organizations must be able to act as advocates or role models; this is inconsistent with their being smokers. Second, such policies help denormalize tobacco use, which is a crucial aspect of many tobacco control strategies. Both of these arguments are problematic.

Role Models, Advocates, and Cessation Advice

The first argument in support of smoker-free and nicotine-free hospitals and health centers is the fact that health care professionals have a role model function and therefore must be nonsmokers. As the president of the Cleveland Clinic explains,

> As a true "health care" provider, we must create a culture of wellness that permeates the entire institution, from the care we provide, to our physical environment, to the food we offer, and yes, even to our employees. If we are to be advocates of healthy living and disease prevention, we need to be role models for our patients, our communities and each other. In other words, if we are to "talk the talk," we need to "walk the walk."[19]

A similar argument can be made for organizations involved in tobacco control, such as the WHO or anticancer organizations. This point is nicely illustrated by Chapman (even though he does not endorse it): "A smoking cancer control advocate walks the thin ice of public hypocrisy which could conceivably undermine the reputation of their agency"; similar concerns would apply if we hired "a deeply tanned white person to work in skin cancer education, or

mammogram and Pap smear refusniks to spearhead these campaigns."[20(p144)] Thus, those representing tobacco control agencies must be nonsmokers so as not to undermine the goals their organization seeks to pursue.

This argument might be extended not just to active smokers but also to anyone who could be perceived to be a smoker. Smokers will be apparent as such to others not primarily because they are observed smoking (in fact, restrictions on smoking in and around many workplaces will make this unlikely). Rather, the smell of cigarettes on clothes, nicotine stains on fingers, or cigarette packs peeping out of bags are likely to reveal someone as a smoker. A nonsmoker who is exposed to secondhand smoke may, just like a smoker, smell of smoke; those who interact with that employee may therefore mistake her for a smoker. Similarly, if we see a packet of nicotine patches in a tobacco control advocate's bag, we may take this to undermine her stance on tobacco control. Thus, the move from nonsmoker to non-nicotine policies could be supported by considerations of this sort: if our concern is with the status of employees as role models and advocates, it may be necessary to bar from employment those who are likely to be *seen* as smokers, and this may include some who are not active smokers.

However, the relevance of the role model and advocate argument weakens the farther removed a particular job or position is from the goals pursued by an organization; it will be much stronger if we are considering, for

example, members of the WHO's Tobacco Free Initiative or nurses who advise patients on smoking cessation than in the case of kitchen staff or positions in the organization's accounts department. In the argument presented here, I focus on positions that are closely connected to antismoking goals. If it is the case that, even then, the role model and advocate argument is problematic, it would be even less plausible for jobs not related to antismoking goals.

The importance of role models in the smoking context is often emphasized in the literature. Health care professionals who smoke can undermine the message that smoking carries health risks. Furthermore, when employees who represent organizations that are actively involved in tobacco control, such as the WHO, are smokers themselves, this may be seen as undermining the credibility of the organization concerned and of the goals it is pursuing.

However, the plausibility of these arguments weakens when we take seriously the addictive nature of nicotine. We know that many smokers would like to quit but find it impossible to do so (in the United Kingdom, for example, 74% of smokers reportedly want to quit[21]), and that the addictive nature of nicotine plays an important role in thwarting smokers' cessation attempts.[22] If smoking is at least in part maintained by nicotine dependence, then being a smoker is perfectly consistent not only with a desire to quit but also with supporting the case for tobacco control. In fact, it is not uncommon for smokers to support tobacco control policies such as

smoking restrictions in public places.[23] Thus, the putative hypocrisy of a smoker supporting tobacco control disappears once the addictive nature of tobacco is fully appreciated. Smoker-free hiring policies therefore cannot be justified by pointing to the idea that smokers cannot be wholehearted advocates of the case against tobacco.

What about the argument that those who are employed by health care organizations must be nonsmokers so that they can be role models for the patients they serve? This suggestion is perhaps most plausible with respect to health professionals who might have to advise patients who use tobacco on cessation.

It should be noted, first, that it is far from obvious that we should expect nurses or doctors to act as role models for their patients. If we did, this would arguably implicate not only health professionals who use tobacco but also those who take other health risks—or who may *appear* to patients to be taking such risks. This might rule out, for example, health professionals who are obese or those who participate in risky sports. The "role model" argument therefore clearly comes with the risk of a slippery slope.

Moreover, even if we do accept that health professionals should be role models for their patients, it is not clear who makes a suitable role model in the smoking context. The literature suggests that smokers are wary of health professionals' advice on smoking, which is often perceived as unhelpful[24] and based on an insufficient appreciation of the addictiveness of

nicotine and the difficulties of quitting.[25] Some smokers report that successful quitters and those who have experience with smoking and its health effects may be better at providing credible and helpful advice on smoking cessation than are those who have never smoked.[26] Given the addictiveness of nicotine, it is not surprising that successful quitters make more impressive role models than do never-smokers. In fact, in substance addiction contexts, former addicts have been involved in the treatment of current addicts precisely because they can be role models for patients.[27]

If successful quitters could have a role model function in smoking cessation, who falls into this category? What we know about smoking cessation suggests that this is a difficult process, often involving relapses and several quit attempts.[14] This suggests that we must be open to the possibility that health professionals can be role models for current smokers even if they are not fully "abstinent" at all times. Thus, health professionals who have quit smoking, even if they have occasional relapses, may be in a better position than never-smokers to provide helpful advice to patients on smoking cessation.

What does this imply for hospitals' hiring policies? Smokers who have no desire to quit may indeed not be suitable role models for patients. However, the exclusion of all those who test positive on a cotinine test is likely to capture applicants who might, in fact, be better role models for patients than are never-smokers. The implications of role model concerns, then, are not as clear-cut as is implied by arguments meant to support nonsmoker and nonnicotine hiring policies.

Denormalizing Tobacco and Tobacco Use

A further aim to be pursued through nonsmoker employment policies, mentioned explicitly by the WHO, is the denormalization of smoking. Denormalization, according to the WHO, aims to

> change the broad social norms around tobacco consumption and exposure to tobacco smoke and thus to push tobacco use out of the charmed circle of a normal, desirable practice to make it an abnormal, undesirable one.[28(p7)]

Denormalization and the decreasing social acceptability of smoking, it has been argued, can make an important contribution to the reduction of smoking rates.[29] Various policies, ranging from smoking bans in public buildings to warning labels on cigarette packs, may contribute to the denormalization of tobacco and tobacco use.[30] Thus, denormalization has become an important aspect of tobacco control and is explicitly endorsed by the WHO.[28] With respect to its hiring restrictions, the WHO explains that "the importance for WHO not to be seen as 'normalizing' tobacco use also warrants consideration in the Organization's recruitment policy."[7(p1)]

Nonsmoker hiring policies can contribute to denormalization efforts through at least 3 mechanisms. First, the direct effect of such policies is, over time, to reduce the number of smokers among an organization's staff. On the assumption that an employee's smoking status cannot be successfully concealed, reducing not just the visibility of smoking in the workplace but also that of smokers themselves, may strengthen antitobacco norms. Second, urine tests are commonly used to screen for illegal drug use; inclusion of cotinine among the substances for which job candidates are tested suggests that tobacco is not a "normal" product but is more akin to the illegal substances for which employers often screen potential employees. This link is implicit, for example, in the Cleveland Clinic's description of its preemployment physical examination as including "urine drug testing including cotinine."[31] Similarly, Franciscan Health System explains that it has "conducted mandatory post-job offer/preemployment drug testing for all new hires. . . . nicotine will be added to substances looked for in this urine test."[3] Finally, nonsmoker hiring policies also have symbolic, "expressive" value. For major hospitals and organizations to have such policies in place makes it appear legitimate that smokers (and, in the case of nonnicotine policies, those associated with smokers and those using nicotine-replacement therapy to quit or remain abstinent) are excluded from (at least some kinds of) workplaces and that false statements about smoking status can be sanctioned with disciplinary action or dismissal.

Although it has been suggested that reducing the social acceptability of smoking can have a significant effect on smoking rates,[29] an important concern about denormalization strategies is that they may lead to, or exacerbate, the stigmatization of smokers.[32,33] Because denormalization strategies emphasize that smoking is "undesirable," "abnormal," and not part of "mainstream" society, they may also give rise to an increasingly negative perception of smokers and, ultimately, their stigmatization.

Such effects are, of course, highly problematic. What is more, they may also run counter to health promotion efforts as such stigmatization may have severe negative effects on individuals and their health. For example, smokers may be more likely to conceal their smoking status and less likely to seek help with cessation if they perceive smoking to be stigmatized.[34,35] Furthermore, it has been suggested that the experience of stigmatization can affect health directly—for example, by increasing blood pressure.[36]

Nonsmoker and nonnicotine hiring policies are particularly vulnerable to concerns about stigmatization. Such policies shift the focus from a behavior (tobacco use) to individuals (tobacco users) and even those in close contact with them. Insisting on cotinine tests also establishes a link between nicotine and illegal drugs. Finally, such policies have symbolic value: as Stuber et al. noted, nonsmoking hiring policies,

> by sanctioning discrimination, abrogate smoker's rights as 'ordinary citizens' by placing 'them' in a category that separates smokers from 'us' (nonsmokers).[37(p421)]

As a method of advancing the denormalization of tobacco, nonsmoker hiring policies are therefore

particularly susceptible to the charge that they stigmatize smokers: such hiring policies lend support to the idea that it is legitimate for employers to refuse to hire smokers and—in the case of nonnicotine policies—those in close contact with them as well as nonsmokers using nicotine-replacement therapy. The possibility that employment restrictions could contribute to the stigmatization of smokers should weigh heavily in our assessment of such policies.

CONCLUSIONS

The move from restrictions on smoking in the workplace to nonsmoker and, more recently, nonnicotine hiring policies represents an important shift in tobacco control that can have significant costs for smokers, those living with them, and those attempting to quit. That smoking is increasingly concentrated among disadvantaged groups who are also more susceptible to job insecurity suggests that such policies must also be assessed from a social justice perspective. Tobacco control and health care organizations have sought to support this move by linking employment restrictions to their organizations' commitments to broader antismoking goals, focusing on the requirement that employees act as advocates and role models and on the contribution that hiring restrictions can make to the denormalization of smoking. Neither of these arguments stands up to scrutiny, suggesting that nonsmoker and nonnicotine hiring policies may damage, rather than support, the fight against smoking. ■

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Type A Behavior Pattern and Coronary Heart Disease: Philip Morris's "Crown Jewel"

| Mark P. Petticrew, PhD, BA, Kelley Lee, DPhil, DLitt, MPA, and Martin McKee, MD

The type A behavior pattern (TABP) was described in the 1950s by cardiologists Meyer Friedman and Ray Rosenman, who argued that TABP was an important risk factor for coronary heart disease. This theory was supported by positive findings from the Western Collaborative Group Study and the Framingham Study.

We analyzed tobacco industry documents to show that the tobacco industry was a major funder of TABP research, with selected results used to counter concerns regarding tobacco and health. Our findings also help explain inconsistencies in the findings of epidemiological studies of TABP, in particular the phenomenon of initially promising results followed by negative findings.

Our analysis suggests that these "decline effects" are partly explained by tobacco industry involvement in TABP research. (*Am J Public Health.* 2012;102:2018–2025. doi:10.2105/AJPH.2012.300816)

THE TYPE A BEHAVIOR

pattern (TABP)—typically characterized by individuals who are highly competitive, ambitious, work-driven, time-conscious, and aggressive—has been the subject of research for more than 50 years. The concept was developed in the late 1950s by American cardiologists Meyer Friedman and Ray Rosenman, who argued that TABP was a risk factor for coronary heart disease (CHD), notably among White middle-class men.[1] This theory appeared to be supported by findings from the Western Collaborative Group Study in 1970,[2] 1974,[3] and 1976,[4] and the Framingham Study in 1980.[5] However, these positive findings proved the exception, and many subsequent reviews have not found strong or consistent evidence that TABP is causally associated with CHD onset or outcome.[6,7] For example, a 2002 systematic review, which summarized the findings of 18 etiologic and 15 prognostic studies, showed that studies reporting a significant association were in the minority in both groups. Subsequent studies also have shown no association with mortality: for example, the PRIME study, which examined psychosocial risk factors for cardiovascular disease in France and Northern Ireland[8]; the GAZEL study, which found no association between type A behavior and mortality in French men, and actually found it to be protective of all-cause mortality in women[9]; and the JHPC study, which found type A not to be predictive of CHD in a Japanese population.[10]

Despite the lack of evidence that it really is a risk factor for CHD, the concept of type A behavior has continued to enjoy public appeal, fostered through popular books by Friedman and Rosenman that describe "how to recognize the deadly Type A pattern in your own personality."[1,11] TABP has also remained the subject of contemporary health research, including epidemiological investigations of CHD[8,9,12] and the featuring of TABP in discussions on the psychosocial causes of health inequalities.[9,13,14] It is also possible to assess type A personality type on a popular Web site "to see if your heart health is at stake by taking this test."[15]

We examined the extent to which the enduring popularity of the TABP concept can be explained, in part, by its interest to the tobacco industry. It is now well documented that the industry has sought over many decades to undermine the scientific evidence on smoking and health. Scientists were paid as consultants and expert witnesses in litigation to defend and promote smoking, and to give the impression of "a chorus of seemingly authoritative voices from respected institutions around the world spreading damaging arguments designed to benefit the tobacco companies and damage health."[16(p979)] The industry also commissioned wide-ranging research to challenge scientific evidence of the harmful health effects of tobacco