Chapter 7

# The implicit ethical claims made in anti-tobacco harm reduction rhetoric – a brief overview


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This paper is adapted from a presentation by CMN at the 2009 International Harm Reduction Association conference, Bangkok, Thailand, with additional material by CVP and CEH; while this version expands substantially on the presentation, it still retains some of the abbreviation and informal citations to philosophical thinkers and theories; a more formal version should be available from the TobaccoHarmReduction.org working paper series in 2010.

Despite an ever-growing base of evidence and support, tobacco harm reduction (THR) – more so than harm reduction in general – has had an uphill battle to gain acceptance as a public health policy. This has occurred despite the lack of any clear and fully-articulated arguments as to why promoting THR is not a good public policy. Statements made in opposition to THR are generally delivered as propaganda, meant to evoke naïve and visceral support rather than reasoned agreement, even when presented in scientific or scholarly contexts. They are typically presented with phrasing that implies an agreed ethic about how people should act and what policies should be made. But can we find any such ethical principles implicit in their arguments, or do attempts to ground anti-THR activism in ethical claims appear to just be rationalization for individual preference? It has been widely pointed out that many empirical claims, implicit and explicit, made in anti-THR statements are unsupported by evidence and often easily demonstrated to be false. What is overlooked is that the implicit ethical foundations for the prescriptive assertions are also left unsupported and, indeed, the ethical foundations are not even identified. Any insistence that something should or should not be done is implicitly invoking a claim about what


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actions and public policies are right and good. However, these implicit ethical claims appear to be little understood by those invoking them.

Only if an argument is examined and presented in its most defensible terms is it possible to assess its validity. Given that anti-THR advocates do not do this for their own claims, it falls to us who support harm reduction and want to seriously examine the arguments for and against it, to try to decipher the underlying ethical positions behind anti-THR claims. In so doing, we find that the implicit ethical bases of the claims are very difficult to justify based on any accepted notion of Western policy ethics.

This paper reports a few of the central examples from our effort to disentangle the many different implied ethical positions that underlie the arguments for and against THR, and reduces them to their objective functions in order to better discuss their credibility. Further analysis of these points can be found in a series of papers that are being collected at or will be added to http://www.tobaccoharmreduction.org/wpapers.htm.

**Acts and Consequences**

In reducing arguments to their underlying ethical statements, it proves useful to focus on the two primary bases of modern Western policy ethics. Consequentialist ethics focus on the worldly outcomes (or, more precisely, the expected value of predicted outcomes) of an act or policy, judging its goodness based on those. This includes the familiar concepts of welfarism and utilitarianism. Deontological ethics focus on the character of an act or policy itself, judging it based on its own properties or its motives, apart from its consequences. This includes many manifestations of familiar Western post-Enlightenment rights-based arguments, as well as more subtle points like Kantian categorical imperatives. The arguments analyzed in this paper seek to identify the implicit consequentialist and deontological arguments used against THR. What is often presented as a third orthogonal category of ethical bases, Aristotelian virtue ethics, are omitted from this brief analysis due to their subtlety (which is to say, they are very difficult to operationalize in a political street fight) and their lack of invocation in any of the language we analyzed. However, it is possible that some rudimentary notion of value ethics underlies some of the thinking of some anti-THR activists.

**Arguments for THR**

To provide contrast, it is worth briefly sketching the simplest ethical arguments in favor of promoting THR (these are expanded upon in the above-referenced working paper collection). From a deontological standpoint, it is the central accepted tenet of modern health ethics that people have a right to make informed choices about their own health, and thus authorities are obligated to tell them that THR is possible and to not interfere with access to low-risk nicotine

products. It has been argued that it is *per se* unethical for authorities and opinion leaders to try to mislead people regarding options that affect their own health (for specific examples relating to THR see: Kozlowski & O'Connor (2003), Kozlowski & Edwards (2005), and Phillips et al (2005)). The principle that individuals should decide what they should do (or what should be done to them) regarding their health, and that authorities have a duty to provide them with accurate information that informs such decisions, is called informed autonomy.

From a consequentialist standpoint, with better health outcomes or greater longevity as the goal, overwhelming evidence suggests that THR would reduce the total health impact of nicotine/tobacco usage by encouraging the smokers who are not going to soon quit to switch to low-risk products such as smokeless tobacco (ST) or electronic cigarettes (e-cigs) (see TobaccoHarmReduction.org, Rodu and Godshall (2006), Phillips (2009 - reprinted in this volume), and Phillips, Heavner, & Bergen (2010 - in this volume)). Moreover, when we realize that longevity or physical health alone is not actually an accepted ethical goal, and analyze the case for THR based on welfare (the overall well being of people, including physical and psychological health and everything else people value), the case for THR is even stronger: Compared to promoting abstinence (which has about the same health benefit for smokers as switching to low-risk alternatives), THR would offer a welfare advantage of minimizing the loss of benefits smokers get from their consumption, by not forcing them to quit tobacco/nicotine to achieve the longevity benefits.

**Arguments against THR**

The previous ethical statements in favor of THR are quite compelling to most people. Most people in our society support informed autonomy or improved health and welfare. (It is beyond the present scope to argue the bases of these ethical principles; this analysis simply starts with them and applies them to the specific case.) The question we should then ask, as advocates of THR, is if there are any equally compelling and logically valid ethical arguments against THR. This is a challenge, because the opponents to THR make lots of assertions, but make almost no attempt to present real arguments, or to justify or defend their claims. The following statements are a few of the seemingly more convincing or more common arguments that arise against THR. We have tried to give the proponents of these the best possible benefit of the doubt and tried to validate their arguments, something the anti-THR activists have not done themselves.

**Argument: If we tell people about ST and other low-risk alternatives, more people will start using nicotine products that have some risk, potentially increasing total risk. Moreover, the low-risk products might be a "gateway" that causes more people to take up smoking, causing further risk still.**

These arguments are grounded in a consequentialist argument based on the objective of maximizing physical health or longevity. They implicitly deny the deontological arguments that it is unethical to mislead people to manipulate their health-affecting decisions, even if it is "for their own good", and that we have a duty to treat people as more than a means to end of improving their health. Moreover, they implicitly elevate health to trumping all other goals by declaring that an increase in health risk is a sufficient objection, regardless of the effect on other contributions to welfare compared to the magnitude of the effect on health. While it would be possible to state (though not empirically defend) these claims in terms of overall welfare loss, we are not aware of anti-THR actors ever having done so.

While the "health promotion" community – the political faction that dominates the public face of public health, though not the actual promotion of public health itself – implicitly claims that maximizing physical health without regard to other human wants is a legitimate goal of social policy, almost no one (probably including themselves if they stopped to think about what they were claiming) would agree. To offer some benefit of the doubt, some commentators who invoke this objective may be implicitly appealing to a narrow definition of the phrase "harm reduction": If total physical harm from using tobacco/nicotine products has increased in the population, then *harm reduction* has not been achieved. However, at best this represents an objection to the jargon, not to the proposed policy. Moreover, this relies on ignoring the spirit in which proponents of harm reduction typically use the term, which is to refer to reducing the risks of something people want to do, so that if they choose to do it they are better off than they otherwise would be.

The most common responses to these claims are not attempts to challenge the claim that physical health outcomes trump all other social and ethical concerns, but are empirical. The claim that the extra users of low-risk products could cause an increase in total risk in spite of the benefits of reduced smoking has been thoroughly debunked (see Phillips, 2009, and the references therein). The arithmetic resulting from the extremely low risk caused by THR products makes it clear that the claim is completely implausible. The gateway claim – that THR will cause some would-be abstainers who start using low-risk products to start smoking when they would not otherwise have done so – while theoretically possible (in the sense that this is true for anything that is not precluded by physical law), has never been empirically supported. Moreover, it relies on an implausible narrative that the people who make the most rational decisions will behave

irrationally: The claim basically translates into "we predict that the people who avoided or quit smoking but adopted low-risk THR products when they learned that they were low risk, and who thus seem to be thoughtful and motivated to avoid the health effects of smoking, will forget the reason they avoided smoking in the first place and switch to it from a low-risk product."

The one part of these claims that is predictably true and empirically verified is the claim that some people who would not be tobacco/nicotine users (either would-be never-users or current smokers who would have quit) because of the health effects, but are interested in tobacco/nicotine and derive some pleasure or other benefit from it, will decide that the benefits warrant the lower cost of the low-risk options. This is simple economics: Using tobacco/nicotine has benefits (for many people) and costs; if the costs are lowered a lot and the benefits are lowered only a little bit (which is the case for many people who substitute other products for smoking), then net benefits increase and more people will get positive net benefits from using such a product. In other words, if the health risk is low enough, and the psychological benefits (pleasure, relaxation, relief from distress, etc.) are high enough, people will rationally choose to use ST or e-cigs. (This argument is presented in more detail in Phillips 2009.) Some confusion has been created by pro-THR advocates who (indefensibly) deny that increased total use is inevitable, rather than denying that this should be considered a problem. Arguments that increased use is a problem in itself, even though it will not plausibly cause an increase in total risk, are addressed below.

**Argument: We will soon eliminate all self-administration of nicotine, so we do not need THR.**

This is a specific case of the "more people will use nicotine if we promote THR" argument. It is based on a purely speculative prediction, since there is no evidence to suggest that current policies will bring about any further substantial reduction in nicotine use, and the results of other drug wars are sufficient evidence of the folly of increasingly prohibitionist policies. What is interesting from the perspective of ethical analysis is the sharp focus this brings to the question of legitimate goals.

When dealing with empirical reality, the goals of reducing the health impacts of tobacco use and of maximizing the welfare of users and potential users are both furthered by promoting THR. If we assume that all physical health costs will be eliminated by the incipient universal abstinence, then promoting THR would actually slightly increase total health risks since low-risk products have trivial, but non-zero, physical health risk. However, declaring that a sufficient reason to oppose educating people about THR is a clear declaration of the primacy of minor health concerns over both individual informed autonomy and welfare. This is a logically well-defined position, and seems to be quite common among anti-THR activists. However, the position runs

contrary to people's actual choices in life, as well as basically all health policy rules outside the realm of substance use.

**Argument: Anything that causes more people to use nicotine in the long run is bad because we should avoid letting people be addicted.**

Any argument that invokes the word "addiction" is inherently slippery, since the term is practically meaningless without a specific definition, which is seldom offered. "Addiction" is used to mean everything from "an acquired compulsion that is so intense it destroys everything else in someone's life" to "any habitual consumption pattern that some people choose but that the commentator disapproves of", and hundreds of variants in between. Moreover, it is quite often used (presumably intentionally in many cases) as a way of confusing the different definitions. The use of "addiction" in moral arguments (as opposed to a shorthand to simply describe a consumption pattern) seems intended to conflate nicotine use with hard drugs that rapidly destroy people's entire lives, or to denigrate the user.

Taken as a consequentialist argument, the argument appears to be that avoiding addiction – whatever that means – should be a goal in itself, apart from the welfare effects of the consumption associated with the addiction. There are compelling policy arguments to discourage behaviors labeled "addiction" that cause people to rapidly proceed on a path of destruction, but this is an argument against the particular behavior based on its consequences, not against addiction as a consequence. The goal of minimizing addiction is even more difficult to justify as a policy ethics goal than the goal of minimizing physical health costs, and not just because it is not well-defined. Like physical health costs, it could be argued that addiction should be considered as a negative in the overall welfare calculation, balanced against other interests, but this is not the form the anti-THR argument ever seems to take.

Some of the language surrounding arguments based on avoiding addiction seems to invoke a misunderstood notion of Kantian autonomy. Kant argued (roughly speaking) that anything that diminishes someone's autonomy to act based on their rational will (the duties defined by pure reason) diminishes the person. Anti-addiction activists may be interpreting such deontological claims as justifying their position. But Kant's notion of what threatened autonomy included all pleasures and worldly goals that we did not choose. With this clarification in mind, it becomes difficult to find an ethical argument that condemns the addiction-quality of nicotine use without also condemning most behaviors whose purpose is to fulfill personal tastes or desires. (Indeed, there is a case to be made that an addiction is somehow better than other preferences since it was self-created, rather than an accident of genetics or social pressures. In any case, anti-THR

activists are unlikely to find ethical justification in Kant, though further analysis is beyond the present scope.)

Of course, puritanical ethical codes have held sway in many governments, with undercurrents throughout Anglophone history and clear contemporary examples found in some Islamist societies. However, despite the existence of such factions, condemnation of the fulfillment of desires is almost universally condemned in serious modern Western discourse about policy ethics. Indeed, if we exclude those anti-nicotine positions that are explicitly attributed to organized religion, we are not aware of any anti-THR activist who actually defends a puritanical ethical code that condemns recreational caffeine or sexual activity alongside nicotine. Thus it is difficult to find a logically defensible anti-addiction or anti-nonautonomous-desire based ethical position, even apart from the difficulty in defining addiction.

**Argument: Anything that causes more people to use tobacco/nicotine in the long run is inherently bad because the goal is vilifying or eliminating all use.**

A clearer version of the more-is-worse argument is simply that the act of self-administering nicotine is bad in itself, and the goal of relevant public policy should be to discourage it, regardless of how great the benefits of use might be or how far the risks can be reduced. This claim is the anti-tobacco (or anti-nicotine) *extremist* position, and many anti-THR activists explicitly identify it as their goal. (Some naïve commentators have objected to the term "extremist", interpreting it as invective, a mistake that may be caused by the U.S. government and its allies using this term as an epithet for its enemies. But, of course, the word has an actual meaning, and the goal of eliminating all tobacco/nicotine use regardless of its benefits and of how low the costs are, and vilifying it pending its elimination, seems to be the most extreme possible position on the matter.)

In pursuit of the anti-tobacco extremist goal, keeping the health risks high (i.e., by discouraging THR so that nicotine users continue to incur the dangers of smoking) is a reasonable tactic, since lowering risks will reduce the incentive people have to avoid the consumption. But can the goal be ethically justified? It is difficult to imagine any legitimate ethical rule that singles out this consumption choice for condemnation, let alone puts the goal above all other concerns. Such line-item specifics are generally a sign that a goal does not stand up to ethical scrutiny, and that someone is trying to cloak their personal preferences in the guise of ethical rules. Moreover, the casuist analysis is fairly damning given the tactic of keeping risks high: Any ethical rule that calls for causing people to needlessly suffer, for no benefit other than trying to discourage them from doing what causes them to suffer because it is bad for them, is highly suspect.

Only occasionally do those who assert the extremist position attempt to justify it. Most often this takes the form of portraying any acceptance of tobacco/nicotine usage as a blight on society or humanity. This borders on pure circularity, begging the question of why usage is bad: If people adopt low-risk tobacco/nicotine products, then more people will be doing a bad thing, which is bad, and therefore promoting THR is bad.

When the argument is phrased in non-circular ways, it is usually the Lovejoy-esque "won't somebody think of the children" (for non-Simpsons fans, see, en.wikipedia.org/ wiki/ Helen_Lovejoy) plea about visibility of use: that if we try to improve the welfare of smokers, we will send the "wrong" message to nonusers by not wholly condemning the behavior. This is basically the same argument that is commonly offered by anti-gay-rights activists who stop short of calling for criminalization of homosexuality but oppose policies aimed at reducing discrimination, facilitating domesticity, or providing public health services. This too borders on the circular: anything that acknowledges the preferences and basic human rights of those who engage in a particular behavior (homosexuality; using tobacco/nicotine) could be interpreted as encouraging the behavior, and since the behavior is bad, encouraging it is bad.

The most logically charitable interpretation of such claims seems to be that the concerns of nonusers trump the concerns (health, welfare, right to honest information) of users, because the latter have made themselves undeserving, and that exposure to low-risk product use will hurt nonusers. While this presents the extremist position as something other than circular or anchored only in individual pique, and thus offers some logic, it fails both empirically (why would nonusers discovering the advantages of low-risk nicotine products hurt them?) and morally. The language is disturbingly similar to the excuses for discrimination against any disfavored group on the basis of race, sexuality, poverty, etc. More formally, imposing costly limitations on one group of people (by misleading them) purely to benefit another group violates most every ethical rule accepted by anyone: utilitarianism, basic civil liberties, health ethics, Kantian duty to not use people purely as means to an end, categorical imperatives about honesty, etc.

**Argument: Public health advocates should never promote something that is not 100% healthy.**

Often, if you ask someone who has never seriously thought about ethics or the practice of medicine or public health what the preeminent health ethic is, they will recall the Hippocratic Oath, and say "do no harm", rather than correctly identifying the principles surrounding informed autonomy. They might then go on to interpret this non-rule as forbidding any action/policy/recommendation that has any possibility of causing any harm. It should be immediately obvious that this is tantamount to a demand for complete paralysis.

No medical or public health action is 100% free of risk of something going wrong. Vaccines and surgery sometimes kill people, mammography sometimes causes cancer, and even a trip for a preventive exam exposes someone to the dangers of transport. Promoting the use of seatbelts reduces, but does not eliminate, the risk of automobile travel (and, indeed, does not reduce the relevant risk nearly as much as THR does). Moreover, automotive safety features, like any other harm reduction measures, make risky behavior less costly (i.e., less health risk), and so people engage in more of it than they otherwise would (driving more, driving faster, etc.). Indeed, in the case of auto safety features, the behavior resulting from greater safety for the occupants of the vehicle creates greater risk for pedestrians and cyclists (the children!). Thus, the "do no harm" pseudo-argument effectively condemns almost all of public health practice. Fortunately no such ethical rule is accepted in our society.

**Argument: Low-risk nicotine products provide smokers a way to avoid suffering in situations where they cannot smoke, and is sometimes even promoted for this purpose, and therefore may actually increase long-run smoking prevalence.**

The reason that this does not read like an argument against THR is that it really is not one. However, currently it is the claim that is probably most commonly used as an attack on THR and so needs to be included in this analysis. It should be immediately apparent that this might constitute an argument against the *availability* of smokeless nicotine products (which is roughly synonymous with low-risk nicotine products), including pharmaceutical nicotine patches, gum, etc. However, given that some kinds of smokeless nicotine products are already widely available in almost every relevant jurisdiction, and that smokers know where to find them and that they can use them in smoke-prohibited situations, this obviously does not constitute an argument against promoting THR. Indeed, it is really an argument in favor of promoting THR, since if smokers are going to use these products anyway, we should endeavor to persuade them of the benefits of switching entirely.

From an ethical standpoint, this erroneous argument is quite a telling statement about the behavior of the anti-tobacco extremist faction. Time and place restrictions on smoking are justified based on concerns about the health of bystanders who might be exposed to second-hand smoke, with the imposition on smokers declared to be an acceptable price to pay. Setting aside debates about the scientific validity of the claims, the ethical argument – about not being the involuntary victim of someone else's behavior – is easy to defend. However, since there was never a social consensus that smokers should intentionally be made unhappy, merely that making them unhappy is a reasonable price to pay to protect others, the existence of restrictions on

smoking cannot justify restricting the availability of smokeless products, let alone hiding the benefits of THR.

When anti-THR activists decry the use of low-risk smokeless products to "get around" the restrictions, they are effectively admitting that they were lying about their motives for restricting the behavior of smokers. They were not trying to protect nonsmokers from the minor effects of small doses of second-hand smoke; they were trying to hurt smokers by leaving them longing for a cigarette. So, whether the goal of that was to motivate smokers to quit or simply to punish the behavior (it is easy to find examples of anti-tobacco extremists openly expressing glee about the suffering of smokers), anything that diminishes the suffering of a smoker undermines the desires of this faction. This presents another casuist observation that seems to condemn the ethics of the extremist agenda. Moreover, the logic of the argument seems to be that punishing smokers is such an important goal that a promising public health policy for helping them should be avoided because, though promoting THR (as opposed to banning nicotine gum) does not even directly affect the attempt to punish the smokers, it might theoretically have some tangential impact on it. It seems a rather damning commentary about those who oppose THR that they actively anchor their position on the ethics and logic of this argument.

**Conclusions**

This attempt to find ethical arguments against promoting THR shows that finding defensible arguments is remarkably difficult. It is possible that anti-THR activists could make a better case for themselves, but if we knew how it could be done, we would have included it. The fact that they have not done so tends to suggest that they agree that it is not possible. While it is never possible to prove the universal non-existence of something, in this case an ethically valid anti-THR argument, the best evidence for the non-existence tends to be strong motivation of a lot of people to find it. Given that there is a large and well-funded industry devoted to making the case against THR, but the case has never been made, the evidence supporting the universal negative is about as strong as it can be.

The best that can be said for the arguments we have identified is that if one accepts an ethical system where physical health trumps all other contributors to welfare, and pursuit of such consequences need not be constrained by individual rights or categorical imperatives, *and* we assume – contrary to all the evidence that exists – that promoting THR would actually increase physical health risks, then there is a case against THR. Alternatively, it is always circularly the case that if a particular behavior – in this case consumption of any tobacco/nicotine product – is simply declared to be unethical, then any effort that might encourage it is also unethical. It should be obvious that allowing people in positions of influence to turn their own minority opinions into declared social ethics is a rather scary way to make social policy.

This analysis suggests that attacks on THR are not based on defensible ethics. They are presented in ways that apparently appear credible to some observers, but seem to be based on undefended ethical positions that, if accepted, would equally condemn a wide variety of other public health activities and a large portion of activities that people choose to engage in. We present this as a challenge and invitation for anti-THR activists to better defend their arguments as stemming from ethical principles that others would accept. If they continue to fail to do so in light of explicit challenges like this one, then those arguments must be judged to be not only unpersuasive, but also inherently unethical to put forward.

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