that "there but for the grace of God go they."

Given nonsmokers' resistance, it would be helpful if employers providing smoking-cessation support engaged in early outreach emphasizing that helping smokers to quit adheres to the principle of risk pooling underlying health insurance. Successful cessation programs could lead to higher productivity and lower insurance contributions for nonsmokers, thereby benefiting all employees.

The goal of reducing smoking rates is important. Although smoking rates among U.S. adults have decreased from 42% in 1965 to 19% today,[5] more remains to be done, particularly for low-income and unemployed populations. Promoting public health is a shared responsibility, and employers have a social obligation to contribute to the public health mission outlined by the Institute of Medicine: "fulfill[ing] society's interest in assuring conditions in which people can be healthy." By cherry-picking "low-risk" employees and denying employment to smokers, employers neglect this obligation, risk hurting vulnerable groups, and behave unethically. The same goes for imposing high penalties on smokers under the guise of providing wellness incentives.

We believe that employers should consider more constructive approaches than punishing smokers. In hiring decisions, they should focus on whether candidates meet the job requirements; then they should provide genuine support to employees who wish to quit smoking. And health care organizations in particular should show compassion for their workers. This approach may even be a win–win economic solution, since employees who feel supported will probably be more productive than will those who live in fear of penalties.

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Conflicts and Compromises in Not Hiring Smokers

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Tobacco use is responsible for approximately 440,000 deaths in the United States each year — about one death out of every five. This number is more than the annual number of deaths caused by HIV infection, illegal drug use, alcohol use, motor vehicle injuries, suicides, and murders combined[1] and more than the number of American servicemen who died during World War II.

A small but increasing number of employers — including health care systems such as the Cleveland Clinic, Geisinger, Baylor, and the University of Pennsylvania Health System — have established policies of no longer hiring tobacco users. These employers might justify such hiring policies in many ways — arguing, for instance, that they're taking a stand against a habit that causes death and disability, that they're sending an important message to young people and others within their communities about the harms of smoking, or that they're reducing their future costs, given that smokers, on average, cost employers several thousand dollars more each year than nonsmokers in health care expenses and lost productivity.

These policies engender controversy, and we recognize that they risk creating or perpetuating injustices. One set of concerns arises from the fact that tobacco use is more concentrated in groups with lower socioeconomic status. Hospitals do better than most institutions at creating employment and advancement op-

portunities for disadvantaged populations. So even though most members of lower socioeconomic groups do not use tobacco, and even though anti-tobacco hiring policies are not intended to reduce jobs for these populations, they are likely to do so inadvertently, at least somewhat.

However, these policies may also save lives, directly and through their potential effects on social norms, and these same disadvantaged populations are at greatest risk for smoking-related harms and ensuing disparities in health. Many Americans see it as perfectly acceptable that most workplaces are smoke-free and that smoking is prohibited in many bars and restaurants. We are reminded of how far we have come in our tolerance for restricting this activity only on visits to other countries, where public smoking is much less restricted, or when we recall the time when airplanes had smoking sections — a notion that seems absurd today.

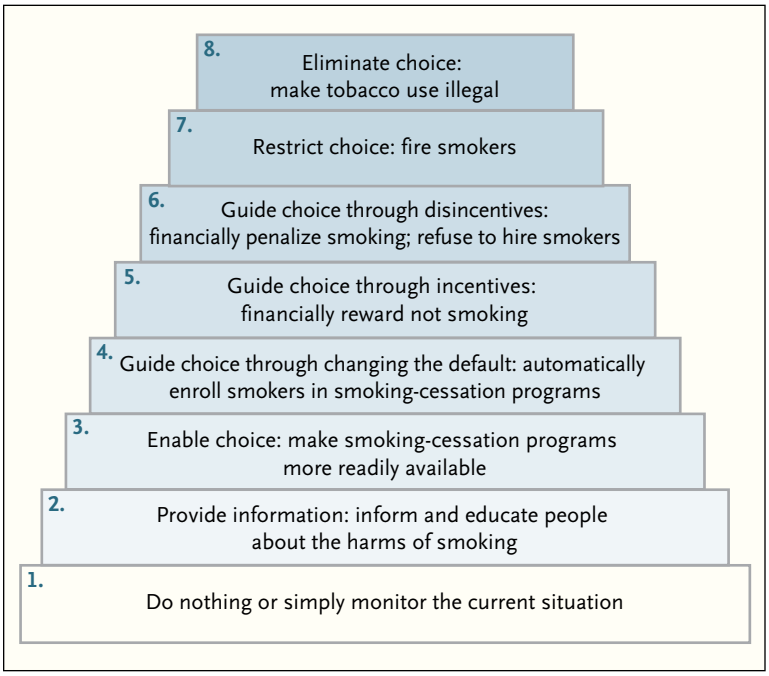
To be sure, many of the restrictive policies we now take for granted were justified not by their effects on smokers but by the harm inflicted on nonsmokers by secondhand smoke. These policies also increased the stigma against smoking, so although there's debate over whether stigma can be used as a tool for good,[2] ultimately these policies almost certainly contributed to the decrease in the prevalence of smoking, not just the limits on where it occurs. For example, the Cleveland Clinic moved to a smoke-free campus in 2005 and stopped hiring smokers in 2007. Reportedly, smoking rates decreased in Cuyahoga County (where the Cleveland Clinic is located) from 20.7% in 2005 to 15% in 2009, whereas the overall rate in the state decreased only from 22.4% to 20.3%.[3]

Similarly, policies against hiring smokers shift the debate from the question of where one smokes to that of whether one smokes. Are these policies aimed at tobacco, which is harmful and destructive, or at people who are addicted to tobacco, who may be seen as victims? Do the policies target legally available products or people who make a personal choice that contributes to a social burden and could conceivably choose otherwise? Are the rules designed to reduce smoking, which is a population health goal, or to fence out smokers, which may be an institutional financial goal? How, exactly, should we look at these policies?

We believe we should see them as one product of a growing recognition that changing behaviors is hard, that combating addiction is harder, and that behaviors that were once seen as exclusively private often have profound societal effects. As a result, many stakeholders are trying to change unhealthy behaviors through mechanisms as varied as legislative requirements for calorie labeling in some restaurants, bans on the sale of large servings of sugar-sweetened beverages, and Affordable Care Act provisions allowing employers to provide rewards or penalties worth up to 50% of employees' health insurance premiums on the basis of health assessments, including smoking status. Those policies would have seemed like hard paternalism back when no one questioned passengers' right to smoke on airplanes, but they might be seen as considerably softer now in light of social trends, and perhaps in the future we won't consider them paternalistic at all.

The Nuffield Council on Bioethics in the United Kingdom has proposed a conceptual ladder of progressively higher levels of interventions aimed at improving health-related behaviors.[4] Finding the ladder useful in the context of smoking, we have laid out an anti-tobacco–intervention ladder that ranges from simply monitoring behavior, to guiding people's choices through increasingly aggressive means, and ultimately to eliminating choice (see figure). An important justification for climbing the ladder is that the gentler interventions that make up the lower rungs haven't resulted in adequate smoking-cessation rates, given tobacco's harms.

For example, we conducted a randomized trial comparing the use of employer-provided financial incentives for smoking cessation, aided by counseling, with an approach in which the same sorts of counseling programs were made available to employees but no incentives were given — effectively comparing enabling choice (rung 3) with guiding choice through incentives (rung 5). In one sense, the results were dramatic: during 12 to 18 months of follow-up, employees in the incentive group had a quit rate that was approximately three times that in the comparison group.[5] But in absolute terms, even the incentive group had an 18-month quit rate of only about 9% — meaning that even with an aggressive system of rewards, 91% of employees who wanted to quit could not. We believe that the severe harms of smoking justify moving higher up on the ladder when lower-rung interven-



Proposed Ladder of Interventions to Reduce Tobacco Use.
Adapted from the Nuffield Council on Bioethics.[4]

tions don't achieve essential public health goals.

Not everyone will see a given approach as achieving the same balance between social goals and effects on individuals. Is it fair to penalize smokers even though the highly addictive nature of nicotine makes their behavior less than entirely voluntary? In many surveys, about 70% of smokers say they want to quit, but only 2 to 3% succeed each year. One reason for this huge gap is that smoking cessation has immediate costs in the form of nicotine withdrawal (i.e., the symptoms of withdrawal and the costs of antismoking treatments), but its benefits in terms of improved health are considerably delayed. Thus, although some people may see anti-tobacco hiring policies as adding economic injury to physical injury, we would argue that such policies also make the benefits of smoking cessation more immediate and so help to counterbalance the immediate costs of quitting.

Do hospitals' anti-tobacco hiring policies send a signal to their patients? Many patients dislike the smell of smoke clinging to a health worker's clothing as he or she leans over them — or at least may see that odor as inconsistent with the values and goals hospitals are supposed to represent. Do hospitals' anti-tobacco hiring policies denormalize smoking and help communities escape tobacco's burden? Critics may argue that these claims are disingenuous, akin to a human resource director's saying to tobacco-using applicants, "Believe me, it's for your own good that I'm not hiring you." But in the long run, such policies may indeed be for their own good.

We recognize that these hiring practices are controversial, reflecting a mix of intentions and offering a set of outcomes that may blend the bad with the good. We know that many companies will want merely to continue their current level of anti-tobacco efforts, but given the threats that tobacco presents to our communities and institutions, we believe it's time to climb another rung on the ladder.

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