

## **How Does a Culture of Health Change? Lessons from the War on Cigarettes**

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### **Abstract:**

This paper focuses on one of the most dramatic changes in the culture of health in the U.S. since World War II: the reduction of adult cigarette smoking from close to half of the population to under 20 percent between the 1960s and the 1990s. What role does culture play in explaining this shift in smoking from socially accepted to socially stigmatized? After surveying how culture has been used to explain the decline in smoking in the fields of tobacco control and public health, we argue that existing concepts do not capture the complex transformation of smoking. We instead suggest a micro-sociological view which presumes that culture may change in response to spatially organized constraints, cajoling, and comradeship. By reviewing two major drivers of the transformation of smoking - the Surgeon General's Reports and the nonsmokers' rights movement - at this micro-sociological level, we show how culture works through social spaces and practices while institutionalizing collective or even legal pressures and constraints on behavior. This conclusion also seeks to explain the uneven adoption of non-smoking across classes, and to reflect on the utility of presuming that a uniform "culture" blankets a society.

**Keywords:** United States; Smoking; Tobacco control policy; Culture; Sociology of Culture; Health Inequalities; Surgeon General's Report

In contemporary public health efforts and public health research, there is a growing focus worldwide on non-communicable diseases. This has been called the "new public health," dating to the 1970s. (Cairney & Studlar, 2014, p. 315). How do we understand and how can we do more to prevent the harm caused by tobacco, alcohol, and processed food and drink industries linked to obesity, diabetes, hypertension, and the tobacco-linked cancers, heart disease, and emphysema? The new public health (NPH) suggests focusing on changing human behaviors one by one. Instead of improving health care or eradicating infectious diseases, proponents of the NPH seek a healthy society through publicizing potential risks and promoting better choices in life (Petersen & Lupton, 1996).

Telling people what is in their own best interest is not in itself enough. Sometimes that does not even work with people who are in pain, seek the advice of a doctor, and receive

prescriptions. Compliance in taking doctor-prescribed medication as directed is about 50 percent, with 20 to 30 percent of prescriptions never even filled. Rates of non-compliance with prescriptions for chronic diseases, like hypertension or diabetes-related illness, are extremely high, in the range of 90 percent (Becker & Maiman, 1975).

And yet – sometimes “telling” works. Sometimes news about famous politicians, athletes, and actors with serious health problems leads people to respond – as, for instance, thousands of people did in scheduling appointments for colonoscopies after President Reagan’s 1985 diagnosis of colon cancer. (Brown & Potosky, 1990) Moreover, we have the example of a remarkable cultural change in smoking – from the 1950s, 1960s, and into the 1970s when more than 40 percent of American adults were smokers to 2013 when it was just 18 percent. Why did smoking decline? Why did about half of all living adults in the United States (U.S) who had ever smoked stop smoking by 2000? (Cummings, 2002, p. 7350)

Usually lauded as “the first major success” of the NPH movement (Studlar, 2014), one could count a myriad of factors that stirred this relatively rapid decline in smoking: shifts in the public agenda, changing socioeconomic circumstances, influential policy networks, active governmental institutions, and new ideas affecting policy (Cairney et al, 2012). But consider that as cigarette smoking declined, more and more non-smokers reported that “being near a smoker makes them feel sick.” (Lader, 2009). This seems a notable indicator of a change in the meaning of and attitudes toward smoking away from a still recent time when smokers were icons of sophistication and people did not “feel sick” near them. How can we explain this cultural shift? Was it a consequence of the successful policy instruments used in tobacco control? Or were those policy instruments successful because of the cultural transformation?

Our effort in this paper is to review the decline in smoking in the light of sociological research and theorizing on cultural change. Distinguishing policy from culture is not easy and may not be helpful. Keeping various components of tobacco control in mind – laws passed to prohibit smoking in restaurants, office buildings, schools, hospitals, public parks; rising scientific knowledge; warning labels, public service advertising, news about smoking; increases in taxation on cigarette sales; and organized anti-smoking groups – we will ask: How have the symbolic boundaries and collective images, attitudes, beliefs, and predispositions around health and smoking been influenced by tobacco control advocacy in the last fifty years? What can we learn from this remarkable transformation to understand the relationship between culture and public health? And what does the uneven adoption of non-smoking across classes tell us about the utility of explanations that imply that a uniform “culture” blankets a society?

We have two goals in this paper. First, we review how “culture,” as an analytical category, has been taken up by public health scholars who have studied the decline of smoking in Europe and North America. After demonstrating the shortcomings of existing approaches, we suggest an alternative view from cultural sociology, which, we believe, better illuminates the complex socio-cultural transformation of smoking. Second, we examine what many judge to be two major culture-related drivers of tobacco control in the U.S. – *the Surgeon General’s 1964 Report on Smoking and Health* and the nonsmokers’ rights movement – to illustrate why our proposed micro-sociological concept of culture is more supple and sensible for explaining the character of smoking decline than concepts deployed by other scholars.

Our focus on the U.S. reflects our U.S.-centered expertise, it does not imply that U.S. tobacco control represents “best practice.” On the contrary, among all the developed countries that have shifted their attitude toward cigarettes since the 1970s, the U.S. has neither the lowest

per capita consumption nor the fastest rate of decline (Pierce, 1989). In tandem with our argument, we certainly do not suggest that a uniquely American culture fully accounts for either the decline in U.S. smoking or the still significant resistance to anti-smoking efforts. The transformation of beliefs and attitudes about smoking in the U.S. mirrors similar trends in European countries, albeit in varying degrees. We believe the way we propose to think about culture, not the specific content of American culture, can be generalized to other national contexts, and can open up the possibility of comparative studies.

### **Three Ways to Think About Culture and Smoking**

In his magisterial account of the cigarette in American history, *The Cigarette Century* (2007), Allan Brandt observed that American society became “far more health-conscious since the 1960s – and more risk averse.” (p. 295) Cigarettes had been a symbol of elegance, of social acceptability, of glamour for close to half a century but no longer: “The cigarette had little standing in a health-conscious culture, increasingly skeptical of an industry whose self-interest had long since been exposed.” (p. 297) Overall, as Brandt efficiently puts it, “The product and its consumer had moved from the normative to the stigmatized” (p. 308).

About that conclusion, there is no dispute. But along the route to it, Brandt sometimes employs the concept of culture in a casual fashion that does not live up to *The Cigarette Century*'s overall sophistication. Brandt deploys “culture” as a factor to explain why Americans took so long to stop smoking after *the Surgeon General's 1964 Report* made it clear that cigarettes kill; for Brandt “American culture” is unusually voluntaristic and presumes it is an individual's responsibility to take up the habit or to quit it. Brandt refers to “widely shared libertarian attitudes about both the role of the state and the behavior of individuals” and what he

dubs “the American individualist credo, ‘It’s my body and I’ll do what I please’” (p. 280).

Although Brandt recognizes ambivalence in American culture over voluntarism, especially over addictions, he concludes, “As a culture, we seek to insist – despite much powerful evidence to the contrary – that smoking remains a simple question of individual agency, personal fortitude, and the exercise of free will” (p. 443).

Brandt’s task was not to elucidate a theory of culture, but nevertheless he operated with one, even if he marshaled it rather gently, and even if his epilogue recognizes that the theory needs to be altered, if not abandoned. His conception of a deep-seated, largely uniform, change-resistance culture – which we will call the “deep values” approach – usually appears in the literature on tobacco control with references to “American individualism” (Bayer & Colgrove, 2004) or “American Puritanism” (Kluger, 1996) or “American anti-paternalism” (Kagan & Vogel, 1993). In each case, culture seems to be a much more coherent “thing” than it is, even in the face of observations that “American culture” has many, and contradictory, strands.

We think there are good grounds for putting aside this “deep values” approach to explain the decline in smoking. It implies a cultural homogeneity that does not exist in reality. Not all Americans are preoccupied with the language of the individual or personal; some are attached to social justice, biblical or civic-republican commitments (Bellah et al, 1985; Horowitz, 1983) or to forms of fraternal solidarity around unions or neighborhood loyalties. Moreover, it lacks specificity with respect to how culture works (Schudson, 1989). For example, if American culture is a set of general abiding values that characterizes the society as a whole, such as individualism, voluntarism, Puritanism, and anti-paternalism, why is the change in smoking more pervasive among more affluent and educated Americans? Why do these values fail to prevent a sharp move away from pro-smoking attitudes?

Another concept of culture in the literature on tobacco control emphasizes that “(persuasive) messages” can change health-related attitudes and beliefs. Scholars cite communication of scientific facts about smoking, their diffusion across various media and borders, and all the other promotional ways of “telling” as processes through which the meaning of smoking changes (Studlar, 2014). The *Surgeon General’s Report on Smoking and Health* (1964), in this vein of explanations, marks the beginning of a dramatic, authoritative, and well-publicized telling. The *Report* has been called the “first salvo in a public health campaign” (Stobbe, 2008, p. 46). The New York Public Library named it one of the top 100 books of the twentieth century (Warner, 2014). And scholars have called it a “landmark report” that “gave tobacco control a higher agenda status, and prompted new ways to consider it.” (Cairney et al., 2012, p. 131).

In the first three months after the publication of the *Report*, per capita cigarette consumption dropped 15 percent. Some who quit in those months, however, quickly relapsed, and by the end of the year the total decline was just five percent. Still, the *1964 Surgeon General’s Report* is understood to be a notable example where “telling” made an impact. More generally, as Kenneth Warner writes, “information transmission played a significant and likely substantial role in altering, in order, knowledge about, attitudes toward, and behavior regarding smoking, especially among the more educated members of society” (Warner, 2006, p. 22). The Surgeon General’s influence was not minimal, but it was by no means an inoculation that provided instant protection. Focusing on the role of persuasive messages fails to explain how ideas and beliefs are perceived in different social contexts and in different social groups (Eliasoph & Lichterman, 2003).

The deep values approach to culture has been invoked (by Brandt and others) to explain the persistence of smoking in the U.S. The persuasive messages concept of culture has been deployed to explain how culture has fostered smoking's decline. But if deep values are so strong, how can new messages overcome them? And if persuasive messages are so powerful, how is it that they act so gradually and are sometimes rejected?

As Orlando Patterson (2014) aptly observes, the study of culture in sociology is "riddled with academic contention." (p. 2). Although culture as a key concern dates back to Marx and Weber, it is a relatively new analytical category in "post-war American sociology with its positivistic and scientific emphasis" (Berezin, 2014). Ann Swidler was among the first sociologists in recent decades to advance sociological thinking about the broad question of the role of culture in social change. In an influential essay, Swidler (1986) argues strongly against the position that Max Weber took in *The Protestant Ethic and the Spirit of Capitalism*, which had become paradigmatic for thinking about the influence of culture in social life. Culture does not provide, Swidler says, "ultimate values toward which action is oriented," but offers a "tool-kit of habits, skills, and styles from which people construct strategies of action" (p. 273). For her, culture does have or can have an "independent causal influence." However, this influence arises only insofar as cultural beliefs and predispositions are enacted in "concrete situations." These situations determine which cultural values "take root and thrive, and which wither and die" (p. 280).

The change toward more powerful micro-cultures of health with respect to smoking between the 1960s and 1990s richly supports Swidler's alternative approach, rather than the "deep values" or Weberian view, wherein individuals take up or quit smoking in ways consistent with a broad national value of personal responsibility, and the "persuasive messages" view that

emphasizes the power of ideas or facts with little attention to their social context. Starting with the late 1960s, we trace the influence of culture through the existing “repertoires” smokers and nonsmokers drew on to justify smoking or its disapproval. The 1970s and 1980s proved what Swidler would call an “unsettled period” in which the shift in social acceptability of smoking occurred alongside changes in the conception of what it means to be a healthy individual as people negotiated the risks of smoking, (reluctantly) acknowledged messages about its dangers, receded from public spaces into smoking-only zones, and conformed their overall lifestyles to new habits.

When anthropologist Clifford Geertz wrote influentially that culture is best seen as “a set of control mechanisms -- plans, recipes, rules, instructions (what computer engineers call ‘programs’) – for the governing of behavior” (1973, p. 44) he may have suggested a more mechanistic view of culture than he intended. He went on, two paragraphs later, to argue that this “control mechanism” view of culture should not be understood to operate as “‘happenings in the head’” but that it must begin with “the assumption that human thought is basically both social and public – that its natural habitat is the house yard, the marketplace, and the town square” (1973, p. 45). “Culture” is comprised of instructions, symbols, meanings, and values that become available, convenient, and salient as they are incorporated into sequences of practices in everyday public life. Culture can usefully be thought of as “ways of organizing action” (Swidler, 1986, p. 277).

This approach to understanding “cultures of health” lies somewhere between the highly and unreasonably aggregated “deep values” notion, and the vastly disaggregated notion that culture can shift in response to any number of individually broadcast or networked persuasive messages. We do not dismiss these two views. Culture as “deep values” captures something real

in social life, and there are “persuasive messages” that make a difference in beliefs, attitudes, and behaviors. We however locate culture and cultural change at a micro-sociological level because it helps us respond to the main puzzle in the decline of smoking: how social habits and beliefs in some classes or communities might change while other sub-communities cling to existing patterns.

The deep values concept may help explain how prevailing dispositions are established or inculcated but an ostensibly coherent “American culture” is not convincing enough to explain the cultural transformation of the cigarette, especially in comparison to other “national cultures.” A “persuasive messages” approach helps to explain how culture works in jolting or nudging individual attitudes with respect to dangers of smoking but falls short of explaining why a widely-broadcast message was not equally influential across social groups. The micro-sociological or situated view of culture we advocate emphasizes the role of social spaces and practices to explain how culture works in institutionalizing social or even legal constraints on behavior.

We review two well-known episodes of tobacco control in the U.S. to illustrate our argument. Out of the many interventions in tobacco control, whose isolated causal effects are almost impossible to pin down, we focus on the role of the *Surgeon General’s* reports and nonsmokers’ rights movement. Their correspondence with the decline in smoking is well documented (as demonstrated below).

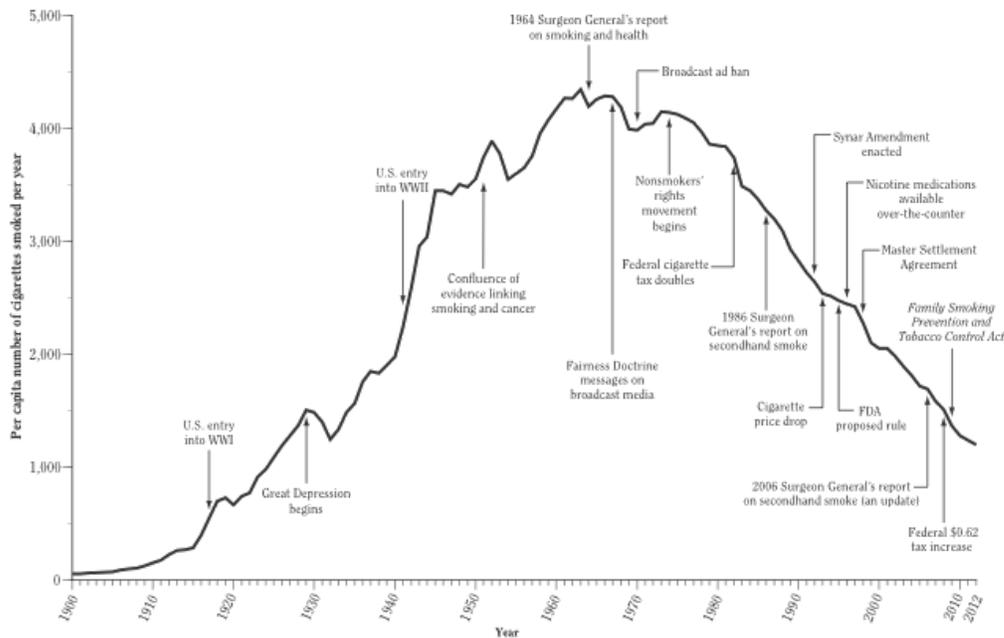


Figure 1: Adult per capita cigarette consumption and major smoking and health events, 1900-2012. Source: U.S. Department of Health and Human Services. (2014). *The Health Consequences of Smoking—50 Years of Progress*. Washington, DC.

We first suggest that the role of *the Surgeon General's Office* in the cultural transformation of smoking goes beyond a one-time, cornerstone event, and derives its influence from the recurrent dissemination of scientific reports that were readily incorporated into anti-smoking advocacy. We then re-examine the success of nonsmokers' rights advocacy, which is noted for helping to make smoking unacceptable (Nathanson, 1999), and highlight the significance of the social settings that were affected by their powerful message -- "Children and bystanders first!" Just as Geertz anticipated, the locus of cultural action was in the "social and

public” world – precisely (in his terms) “the house yard, the marketplace, and the town square.”

With nonsmokers’ rights advocacy, cultural action was to be found in the elevator, the restaurant, the airline cabin, and even in those central locations of private space that occasionally become public – the private automobile (“I would appreciate it if you do not smoke in my car”) and the private home (“We don’t allow smoking in the house”).

### **The Surgeon General Reports and the Authority of Science**

Anthony Komaroff, the editor in chief of Harvard Health Publications, was a first-year medical student when the 1964 *Surgeon General’s Report* came out. “I’m not sure at the time that I knew the U.S. had a Surgeon General,” recalls Komaroff (2014), but he vividly remembers the impression it had on his mother, who had been smoking for many years: “She wasn’t wowed by the science or the weight of the evidence. Instead, she was impressed by the fact that America’s “top doctor” was advising her, and others like her, to stop smoking. She didn’t follow his advice right away, but eventually did.”

The 1964 *Surgeon General’s Report* was not the first expert analysis to declare that smoking was dangerous. In 1962, a nine-member panel chosen by the prestigious Royal College of Physicians (RCP) in Britain had issued a seventy-page report that convincingly presented smoking as a major cause of lung cancer (Berridge, 2004). It was not even the first Surgeon General’s Report on smoking in the U.S. In July 1957, after organizing a group of scientists to review studies on smoking and health, then-Surgeon General Leroy E. Burney issued the “Joint Report of Study Group on Smoking and Health” that reported, “[E]xcessive cigarette smoking is one of the causative factors in lung cancer” (Kluger, 1996). Although this “tepid” statement, as

described by historian Richard Kluger (1996), received some publicity, no decline in cigarette consumption followed the 1957 report.

There was no instant change after the 1964 report either. Most smokers in the U.S. did not quickly follow the advice of Surgeon General Luther Terry. Still, whatever influence the *Surgeon General's Report* had, it did not operate alone and, as Cairney and Studlar (2014) observe, “at least in politics, there is no such thing as self-evident truths that sweep old ideas aside. The process of turning evidence into policy is a battle like any other” (p. 320).

That it would be a battle is something Surgeon General Luther Terry anticipated, well before the first words of the report were drafted. Dr. Terry was a “honey-voiced Alabaman who, as a youngster, had picked tobacco” (Kluger, 1996, p. 460). President John F. Kennedy asked him to put together an advisory committee to investigate the relationship between smoking and health in 1962 against a backdrop of increasing disquiet about the effects of smoking on health and the tobacco industry’s forceful denials. Out of a list of 150 biomedical scientists, Terry carefully picked ten members (five smokers, five non-smokers) with advice from various medical, industry, and government organizations, such as the Tobacco Institute, federal agencies, and the President's Office of Science and Technology. To offset any complaints from the tobacco industry, all of the organizations consulted, including the industry’s own Tobacco Institute, had veto power in the selection of panelists.

The Committee normally met at the National Library of Medicine in Bethesda in a windowless room where the panelists and their working papers were strictly isolated. The room was “smoke-filled” and “littered with ashtrays” (Brandt, 2007, p. 220). After thirteen months of research and deliberation, the Committee concluded, in terse, scientific prose, that “Cigarette smoking is a health hazard of sufficient importance in the United States to warrant appropriate

remedial action” (USDHEW 1964, p. 33) Two chapters of the report were devoted to the methods and the criteria employed to make inferences about cause and effect relationships. What distinguished the report was the “care its members took in examining the evidence, the quest for explicitly stated criteria in reaching their collaborative judgment, and their willingness to engage the counter-arguments put forth by spokesmen for the tobacco industry” (Kluger, 1996, p. 511).

Dr. Terry carefully managed the media and the report itself became a dramatic, nationally televised event. Released on a Saturday to minimize any effect on the stock market, it was on the front pages of Sunday newspapers across the country (Parascandola, 1997). All of the reporters were required to remain for the entire press conference, and allowed to study the report for an hour before they could ask questions. “Cigarettes Peril Health, U.S. Report Concludes; ‘Remedial Action’ Urged” read the front page of *the New York Times* with a picture of Luther Terry next to it. *The New York Herald Tribune*’s science writer, Earl Ubell, found the report “far harsher than anticipated” and noted that it shifted “the burden of disproof” to the industry (Kluger, 1996, p 535). *The Washington Post* said the Committee established “beyond reasonable challenge” that smoking is a serious danger to health.

Eleven days after the 1964 report, the Federal Trade Commission (FTC) proposed rules requiring cigarette manufacturers to disclose on packaging and advertising that smoking is dangerous to health (Cummings, 2002). Before the FTC rules could take effect, however, Congress passed the Cigarette Labeling and Advertising Act of 1965, which mandated the milder statement “Caution: Cigarette Smoking May be Hazardous to Your Health.” One of the sponsors of the bill, Maurine Neuberger, a Democrat senator from Oregon and an early consumer advocate, had long been vocal about the hazards of smoking. She had even written a book critical of the tobacco industry -- *Smoke Screen: Tobacco and the Public Welfare* (1963). But her prior

efforts to create a commission on tobacco and health fell through. The 1964 report gave bureaucrats at the FTC and legislators such as Neuberger an opportunity to make their move.

Studies on warning labels, however, showed that they were largely ineffective (Simonich, 1991). Restrictions on advertising demonstrated only marginal impact (Schudson, 1993). While these policy tools disappointed as immediately effective steps toward tobacco control, *the 1964 Report's* significance lies in the way it started building an institutional voice for the scientific research about smoking. One of the overlooked mandates of the Cigarette Labeling and Advertising Act of 1965 was the requirement that the FTC and the Health, Education, and Welfare (HEW) department would report annually to Congress, through the Surgeon General's Office, on the effectiveness of cigarette advertising, labeling, and the relationship of smoking to health (Kluger, 1996; Nathanson 1999). The Surgeon General's subsequent series of reports together have gradually attained what sociologists Margaret Somers and Fred Block (2005) call "epistemic privilege" – the unusual capacity of a few ideas "to undermine, dislodge, and replace a previously dominant ideational regime." (p. 265) An active government agency that sponsored continuing research and information, along with vocal Surgeon Generals such as Luther Terry or Everett Koop who forcefully rallied tobacco control as a major issue, have regularly appeared as a trustworthy voice in the media, and bolstered public policy positions as well as local advocacy efforts.

Another contributing factor to the cultural influence of Surgeon General's Reports are the rising practices of "risk assessment" that have become commonplace since the 1970s in policymaking (Jasanoff, 2011). The Surgeon General's Office was able to so successfully claim epistemic leadership on the risks of smoking out of not only its own combination of scientific, political, and media savvy, but also a growing public adaptation to risk assessment. The Surgeon

General's reports construct a medicalized and environmental conception of smoking as the chief source of risk to people's health, which culturally resonated with the efforts of nonsmokers' rights movements.

Historian Virginia Berridge (1999) contends that a "symbiotic relationship" between science and policy advocacy has emerged over time to the extent that, in some instances, Surgeon Generals were vocal about nonsmokers' rights even before the scientifically "authoritative" reports appeared. As Surgeon General's reports appeared – 32 of them since 1964, "Little more in the way of scientific evidence was required for movement entrepreneurs to persuasively argue that involuntary exposure to this deadly product was dangerous to nonsmokers as well" (Nathanson, 1999, p. 450). Those reports were responsive to both organized and unorganized nonsmokers' concerns on the ground, as in documenting the effects of second-hand smoke in 1986, nicotine addiction in 1988, and youth tobacco use in 1994. As we will show in the next section, the moral certainty lent by the Surgeon General's Office to anti-smoking concerns effectively certified the loosely organized efforts of anti-smoking activists.

The *1964 Surgeon General's Report*, then, was a cultural force not only as a powerful message about the causal relationship between smoking and cancer risks but as an ongoing institution and a shifting set of messages tailored to the changing focal concerns of the anti-smoking public health movement and specifically the emerging politics of non-smokers' rights. The Surgeon General's reports were not isolated "persuasive messages" but socially embedded messages, entering not so much into the heads of individuals reading reports as into their habits in living social and public lives.

## **Smoking as a Danger to Non-Smokers**

*The 1964 Report* affirmed the status of cigarettes as dangerous objects, but smoking did not become a public nuisance overnight. The tobacco industry aggressively denied the scientific research, and attempted to showcase cigarette consumption as an individual choice and responsibility (Brandt, 2007). How did, then, the image of the smoker change from “Marlboro man” independence and cool to a socially irresponsible person?

Public health scholar Kenneth Warner (1981) estimated that in the absence of an organized anti-smoking campaign, cigarette consumption would have exceeded its 1978 level by more than a third instead of declining annually since 1973. “Both declining consumption and growth in legislation (restricting smoking in public places) probably reflect a prevailing nonsmoking ethos,” argues Warner (1981, p. 730). This new ethos arose out of a concern for ‘innocent victims’ - children and bystanders, which has effectively carved out smoking-only zones through local, state, and some federal regulation, thereby profoundly shaping the sociability of smoking. As Allan Brandt (1998) observes, “The same culture that celebrated the individual risk-taking strongly condemned the imposition of risk on others” (p. 171).

The history of legislation that divides smokers and nonsmokers in public places dates back to 1949 when New Hampshire restricted smoking in public transportation. In 1956 Maine followed New Hampshire, and in 1967 Michigan passed a law that prohibited smoking in elevators. In 1971 the then-Surgeon General Jesse L. Steinfeld took up the issue and said, “Nonsmokers have as much right to clean air and wholesome air smokers have to their so-called right to smoke, which I would redefine as a ‘right to pollute.’” He then called for a ban on smoking in all confined spaces by asking to “reinterpret the Bill of Rights for the nonsmokers as

well as the smoker” (Steinfeld, 1983, p. 1258). This initial call, however, fell on deaf ears on Capitol Hill.

Sociologist Constance Nathanson (1999) identifies two types of activists in the local organizing of nonsmokers’ rights: those who had lost their loved ones to smoking and those who were irritated by tobacco smoke. Betty Carnes, an ornithologist from Arizona, had lost her best friend to lung cancer at the age of 29. In 1971, Carnes persuaded American Airlines to become the first airline to establish a no-smoking section. She then spearheaded the movement that in 1973 prodded Arizona to become the first state to limit smoking across a wide range of public places. Richard Kluger (1996) notes “She made numerous television appearances, sent off 300-word telegrams to resistant lawmakers, and dispensed thousands of her “Thank You for Not Smoking” signs (p. 423). The Arizona law prohibited smoking in elevators, indoor theaters, libraries, art museums, concert halls and buses. The next year, it was broadened to include doctors’ waiting rooms and it restricted smoking in hospitals.

Clara Gouin, who founded the Group against Smokers’ Pollution (GASP) in Maryland in 1971, had lost her father to lung cancer. From its inception, GASP set two goals: to “get nonsmokers to protect themselves” against the irritating effects of cigarette smoke, and “to make smoking so unpopular that smokers would quit” (Nathanson, 1999). What started as meetings with friends in living rooms or at church soon spread across the country, and local chapters were formed in Berkeley and San Francisco. These small and autonomous chapters first had modest goals, such as making meeting rooms, doctors’ offices or hospitals smoke-free (Nathanson, 1999). In the mid-1970s, however, their focus shifted from “passing out leaflets and buttons to the passage of state and local antismoking regulations” (Hanauer, Barr, & Glantz, 1986, p. 2).

In 1975, the Minnesota Clean Indoor Air Act made it illegal to smoke in almost all confined places unless explicitly permitted. Subsequently, small independent groups in Florida and California sponsored initiative measures at the polls to enact clean indoor air legislation. Initially, the tobacco industry vigorously opposed all such efforts. In 1980 a new local group, which had been previously defeated twice in trying to pass clean indoor air legislation in California, formed Californians (later Americans) for Nonsmokers' Rights. This group targeted local rather than state ordinances where the tobacco industry's campaigns "would not work as effectively as well-organized residents who knew the members of the city council and favored the ordinance" (Glantz & Balbach, 2000, p. 22).

In 1981, this local movement registered its first victory in Ukiah, a small community north of San Francisco. By May 1983, twenty-one cities or counties had passed local indoor air ordinances. By the end of 1986, 112 California cities and counties had enacted tough worksite ordinances of their own; and by October 1988, this number had grown to 158 in California (and 289 nationwide) (Glantz & Balbach, 2000, p. 32).

The shift toward anti-smoking attitudes and behaviors in the 1980s and 1990s was led by people who already felt deserving of recognition and support -- white, middle class, well-educated, and politically active, but also others, like airline attendants whose organized efforts helped secure restriction and then prohibitions on smoking in flight (Pan et al, 2005). As these concerned citizens continued challenging the status quo of the cigarette, they found support from the scientific community. Franklin Zimring (1993) argues that during the 1980s, researchers grew much more interested in questions of morbidity and mortality among nonsmokers exposed to smoking. The number of articles about the impact of passive smoking on health "started as a

trickle in the late 1970s and soared from 28 studies in 1981 to 213 in 1989” (Zimring, 1993, p. 107).

A month after Dr. Everett Koop was sworn in Surgeon General in 1982, he held a press conference on a new report and called smoking “the most important public health issue of our time” (Stobbe, 2008, p. 86). In 1986 a new report concluded that, “Involuntary smoking is a cause of disease, including lung cancer, in healthy nonsmokers” (USDHHS1986, p. 7). The validity of the anti-smoking movement was further cemented two years later when the 1988 Surgeon General’s report provided evidence that cigarettes and other forms of tobacco were addictive.

The harmful effects of second-hand smoke are far less than those of direct intake, but as the concerns of anti-smoking activists converged with the questions of biomedical researchers, and supported by the Surgeon General’s Office and later by the Environmental Protection Agency (1992), the image of the smoker shifted from someone who chose to harm oneself, to someone whose habit harmed others, to someone addicted so that smoking had ceased to be a choice.

The anti-tobacco movement has not only rendered the physical proximity to smokers dangerous, but also legitimized the unpleasant smell of smoking as a reason for displacing it from public spaces (Bayer & Stuber, 2006). The growing stigma of smoking was perceived more strongly by more educated and white people than less educated, Black, or Latino groups (Stuber, Galea, & Link, 2008). Nathanson (1999) describes “the shock we feel when a professional colleague lights up a cigarette” that had in short order become incompatible with high professional standing (p. 480). As mostly white and middle class people targeted others much

like themselves with respect to the new norms and aesthetics of being healthy, tobacco control advocacy gained further success (Nathanson, 1999).

The *1988 Surgeon General's Report*, which concluded that nicotine is “a powerfully addicting drug” helped secure the cultural dethroning of the cigarette and paved the way for *the 1993 Report* that focused on children and youths as victims of the tobacco industry. When the FDA intervened in tobacco control in 1995, it presented two main concerns: first, that tobacco companies manipulated nicotine levels to keep smokers addicted, and second, that smoking is a “pediatric disease,” usually acquired first when people are minors (Bayer & Colgrove, 2004). Studlar (2008) notes that these denormalization efforts coincided with economic arguments in the 1990s that state taxpayers bore the brunt of health care costs. Lawsuits by state attorney generals, working together, followed. Revelations from tobacco industry documents during litigation along with the embarrassing denials before Congress by corporate executives that smoking is detrimental to health further contributed to the stigmatization of the tobacco industry (Studlar, 2008).

In the late 1990s and early 2000s, increasing numbers of major cities and states passed comprehensive ordinances to ban smoking in most workplaces, restaurants and bars. In 1997, President Bill Clinton signed an executive order establishing a smoke-free environment for federal employees and all members of the public visiting federally owned facilities. The following year, the U.S. Senate banned smoking in the Senate's public spaces.

When Barbeau et al. (2004) analyzed data from the 2000 National Health Survey they found “no patterning by socioeconomic position... for attempts at quitting” (p. 277). Their results echo the Gallup polls in the 1990s that demonstrated that 95% of Americans claimed to believe smoking was harmful to health. This is a strong indicator that smokers respond to information in

scientific reports distributed in the news media and mandated on cigarette packaging. But if a culture of health were about the direct translation of beliefs into behavior, of symbols into social action, smoking would not only be far lower than it is today, but it also would not be such a stratified practice. There is still wide variation in smoking rates across states, and statewide bans on public smoking, or lack thereof, strongly correlate with consumption patterns. Similarly Barbeau et al (2004) show that “success in quitting... [is] strongly positively related to socioeconomic position, across all racial/ethnic groups and in the total population” (p. 277). In other words, smoking is a social behavior that responds to the convenience or inconvenience of smoking, and this is influenced by legislation, social attitudes, and social prevalence in one’s own reference groups.

## **Conclusion**

By the early 2000s, the decline in smoking was secure, but the war on cigarettes is not over. Smoking persists and follows patterns of education and class, putting already vulnerable groups in society at higher risk of illness and death.

Most scholars of public health and policy would agree that culture matters in the decline of smoking. What we have tried to analyze here is *how* culture matters. And what needs to be understood, as others have observed, is not only that the U.S., like many other countries at the same time, experienced a sharp decline in smoking, but that that decline had its limits, especially in terms of social class. What does this review of the history of tobacco control in light of our micro-sociological view of culture add to the extensive literature on the decline of smoking? Studies that trace cultural components in political processes tend to separate culture from social structure for analytic purposes (Steensland, 2008). Examining the recent history of tobacco

control in the U.S, however, demonstrates how that division obscures the dynamic co-evolution of “symbolic boundaries” and “social boundaries” (Bail, 2008). What separates the image of the irresponsible, morally weak smoker from one of a non-smoker who is environmentally conscious, informed of biomedical research, risk-averse, and responsible is both the scientific consolidation that smoking imperils health and the anti-smoking practices that emphasized the danger of smoking to children and other innocent bystanders. Science, symbolism, and society interacted as the regular public reporting of scientific research publicized the varying “risks” of smoking and lent authority to the attitude that “If you can smell it, it may be killing you” (Bayer and Bachynski, 2013). As nonsmokers’ rights advocates successfully made more spaces smoke-free zones, smokers were repeatedly reminded that many people around them, including a scientific consensus, found their habit toxic.

Not everyone stubbed out their cigarettes. Today there is a strong correlation between class and smoking; less affluent and less educated people are far more likely to be smokers than middle class and upper middle class people (Barbeau et al, 2004. Bayer & Colgrove, 2002). The positivist, medicalized approach to tobacco control coupled with the strong visibility of anti-smoking efforts, such as segregated public spaces or “no smoking” signs, spoke mainly to the middle class, educated segments of society, particularly at a moment of growing awareness of “risk” in general.

Smokers who try quitting but relapse point out that smoking helps them cope with stressful aspects of their lives (Wiltshire et al, 2003). Those who do not work in white-collar work places or do not have college-educated, upper-middle-income friends who rarely tolerate smoking are more likely to fail at quitting. Current smoke cessation programs and close substitutes of cigarettes, such as nicotine gums, are mostly by prescription -- thereby having a

certain type of insurance continues to be a decisive, class-related factor in quitting (Lillard et al, 2007).

Cultural repertoires become influential only in certain contexts. Thus, we trace the cultural components of the decline in smoking through 1) what might seem the institutionally weak, but culturally significant role of the Surgeon General's Office that centralized and lent scientific credibility to the concerns of anti-smokers over time, and 2) the social rally of an existing predisposition, e.g. protection of innocent bystanders, in "the social and public world" by legislating local clean indoor air ordinances.

A few resonant phrases – "human thought is both social and public" (Geertz, 1973), "toolkit of habits, skills, and styles" (Swidler, 1986), and "epistemic privilege" (Somers & Block, 2005) – comprise less than a theory but more than a vague guideline. Our analysis joins the calls for improving the specification of cultural mechanisms in policy studies, and, in our case, public health (Steenland, 2008). We contend that, especially in times of transformation, trying to disentangle structural constraints and historical circumstances from cultural factors might obscure, rather than illuminate, the causes and consequences of change. In the case of the decline in smoking, institutional contexts and social spaces, in which beliefs and behaviors about cigarettes were formed and enacted, shaped the adoption of non-smoking more among wealthier and better-educated Americans than those less well off. Any attempt to define or mobilize "cultures of health" should understand that cultural elements of social transformation constitute and interact at a micro-social level with other factors to influence health outcomes. Reducing culture to omnipresent values or the spread of messages neither recognizes how "culture" actually works nor offers a useful blueprint for developing a cultural approach to health reform.

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