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

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Abstract: While smoking has been restricted in workplaces for some time, a number of health care and others organisations with goals connected to tobacco control have taken the further step of implementing employment restrictions. These restrictions apply to smokers and, in some cases, anyone testing positive on cotinine tests, which also capture users of nicotine-replacement therapy and those exposed to environmental tobacco smoke. Such policies are defended as closely related to broader anti-smoking goals: first, only non-smokers can be role models and advocates for tobacco control; second, non-smoker and 'non-nicotine' hiring policies help denormalise tobacco use, thus advancing a central aspect of tobacco control. However, as I argue in this paper, these arguments are problematic: not only can hiring restrictions come into conflict with broader anti-smoking goals, they also raise significant problems of their own.

INTRODUCTION

Restrictions on smoking in the workplace have become common in many parts of the world. More recently, however, a number of organisations have taken the further step of implementing non-smoker hiring policies, which bar tobacco users from employment. Some hospitals have even put in place what they call 'non-nicotine 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 who are exposed to environmental tobacco 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 as smoking is more prevalent among lower socio-economic 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 organisations 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; further, these policies contribute to anti-tobacco efforts by further denormalising tobacco use. If these arguments succeed, we may judge these benefits to outweigh the costs of such policies. However, as I argue in this paper, these arguments are inconsistent with other goals and concerns of the tobacco control community and may in fact run counter to the pursuit of anti-smoking goals.

THE MOVE FROM SMOKE-FREE TO SMOKER-FREE AND 'NICOTINE-FREE' WORKPLACES

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 non-smokers from the harmful effects of environmental tobacco smoke.

However, a number of organisations have gone further, not only banning smoking from their premises, but implementing non-smoker 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 organisation'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 two 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 emphasise 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 use tobacco has been reported.[8] [9]

Some US hospitals and health care organisations – including the Cleveland Clinic, Franciscan Health System in Washington and Memorial Health Care System in Tennessee – have taken the further step of denying employment not only to smokers but 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 over the past few 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 environmental tobacco smoke or use of cessation aids that contain nicotine.[12] As one organization – Franciscan Health System – explains, '[t]he 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 'non-nicotine hiring policy'.[3]

In the remainder of this paper, I use the terms 'non-smoker' and 'non-nicotine 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 'non-smoker' 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 NON-SMOKER AND NON-NICOTINE EMPLOYMENT POLICIES: UNFAIRNESS AND INEQUITY

Non-smoker and non-nicotine 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. Even though it has been suggested that non-smoker 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 is successful and that relapse is common.[14]

The move towards non-nicotine policies is particularly problematic. This move will affect those using nicotine-replacement therapy to assist quit attempts or to maintain abstinence. Further, because they will also capture those exposed to environmental tobacco smoke, such policies effectively punish individuals for the smoking behaviours 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.[1] Job candidates from higher socioeconomic backgrounds will also have easier access to cessation resources and, on the whole, they will also be better positioned to find 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 non-smoker and non-nicotine hiring policies is therefore likely to be borne by those job-seekers who are already disadvantaged.

However, even if non-smoker and non-nicotine 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

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[1] The University Medical Center in El Paso, Texas, which stopped hiring smokers in October 2010, was reported (in February 2011) to have excluded 14 job candidates from employment because they were tobacco users; of these, one was a nurse and the remaining 13 support staff.[9] This is, of course, only anecdotal evidence; further, when non-smoker or non-nicotine hiring policies are appropriately advertised, those who expect to test positive may simply refrain from applying.

among youth. As I argue in the remainder of this paper, this line of argument is unlikely to be successful with respect to non-smoker and non-nicotine hiring policies.

EMPLOYMENT RESTRICTIONS AND THE FIGHT AGAINST SMOKING: ADVOCACY, ROLE MODELS AND DENORMALISATION

Organisations whose goals relate to tobacco control defend non-smoker and non-nicotine hiring policies as closely connected to the pursuit of such goals. Health care and tobacco control organisations 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 organisations must be able to act as advocates and/or role models; this is inconsistent with their being smokers. Second, such policies help denormalise tobacco use, which is a crucial aspect of many tobacco control strategies. As I argue below, both these arguments are problematic.

ROLE MODELS, ADVOCATES AND CESSATION ADVICE

The first argument in support of smoker-free and nicotine-free workplaces in hospitals and health centres is the fact that health care professionals have a role model function and therefore must be non-smokers. 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 organisations involved in tobacco control, such as the WHO or anti-cancer organisations. 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 spear-head these campaigns'.[20] Thus, those representing tobacco control agencies must be non-smokers so as not to undermine the goals their organisation seeks to pursue.

Arguably, this argument extends not just to active smokers but 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, it is the smell of cigarettes on clothes, nicotine stains on fingers or cigarette packs peeping out of bags that are likely to reveal someone as a smoker. A non-smoker who is exposed to environmental tobacco 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 non-*smoker* 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/advocate argument weakens the further removed a particular job or position is from the goals pursued by an organisation; 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 organisation's accounts department. In the argument presented here, I focus on positions that are closely connected to anti-smoking goals. If it is the case that, even then, the role model/advocate argument is problematic, it would be even less plausible for jobs not related to anti-smoking goals.

The importance of role models in the smoking context is often emphasised in the literature. Health care professionals who smoke can undermine the message that smoking carries health risks. Further, 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 organisation concerned and/or of the goals they are pursuing.[20]

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 UK, 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.[e.g. 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 organisations must be non-smokers 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 those who have never smoked.[26] Given the addictiveness of nicotine, it is not surprising that successful quitters make more impressive role models than

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.[e.g. 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 never-smokers. The implications of role model concerns, then, are not as clear-cut as is implied by arguments meant to support non-smoker hiring policies.

DENORMALISING TOBACCO AND TOBACCO USE

A further aim to be pursued through non-smoker employment policies, mentioned explicitly by the WHO, is the denormalisation of smoking. Denormalisation, 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] Denormalisation 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 denormalisation of tobacco and tobacco use.[30] Thus, denormalisation 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]

Non-smoker hiring policies can contribute to denormalisation efforts through at least three mechanisms. First, the direct effect of such policies is, over time, to reduce the number of smokers among an organisation'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 that of *smokers* themselves, may strengthen anti-tobacco 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 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 their pre-employment physical exam as including 'urine drug testing including cotinine'.[31] Similarly, Franciscan Health System explain that they have 'conducted mandatory post-job offer/pre-employment drug testing for all new hires. . . . nicotine will be added to substances looked for in this urine test'.[3] Finally, non-

smoker hiring policies also have symbolic, 'expressive'[2] value: for major hospitals and organisations to have such policies in place makes it appear legitimate that smokers (and, in the case of non-nicotine 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.

While it has been suggested that reducing the social acceptability of smoking can have a significant effect on smoking rates,[29] an important concern about denormalisation strategies is that they may lead to, or exacerbate, the stigmatisation of smokers.[33, 34] Because denormalisation strategies emphasise 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 stigmatisation.

Such effects are, of course, highly problematic. What is more, they may also run counter to health promotion efforts as such stigmatisation 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 stigmatised.[35, 36] Further, it has been suggested that the experience of stigmatisation can affect health directly, for example by increasing blood pressure.[37]

Non-smoker and non-nicotine hiring policies are particularly vulnerable to concerns about stigmatisation. Such policies shift the focus from a behaviour (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. note, non-smoking hiring policies, 'by sanctioning discrimination, abrogate smoker's rights as "ordinary citizens" by placing "them" in a category that separates smokers from "us" (non-smokers)'.[38] As a method of advancing the denormalisation of tobacco, non-smoker hiring policies are therefore particularly susceptible to the charge that they stigmatise 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 non-nicotine policies – those in close contact with them as well as non-smokers using nicotine-replacement therapy. The possibility that employment restrictions could contribute to the stigmatisation of smokers should weigh heavily in our assessment of such policies.

CONCLUSION

The move from restrictions on smoking in the workplace to non-smoker and, more recently, non-nicotine hiring policies represents an important shift in tobacco control, which 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.

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[2] The expressive function of legislation is discussed by, for example, Cass Sunstein.[32] While the policies under consideration here are not legislation, it is reasonable to think that policies put in place by organisations may similarly have an expressive function.

Tobacco control and health care organisations have sought to support this move by linking employment restrictions to their organisations' commitments to broader anti-smoking goals, focusing on the requirement that employees act as advocates and role models and on the contribution that hiring restrictions can make to the denormalisation of smoking. Neither of these arguments stands up to scrutiny, suggesting that non-smoker and non-nicotine hiring policies may damage, rather than support, the fight against smoking.

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