US-CHINA LAW REVIEW

VOL. 13 **April 2016** **NO. 4**

WHY "SUING THE BASTARDS" IS MORE EFFICIENT IN FIGHTING UNHEALTHY BEHAVIORS THAN EDUCATION

John F. Banzhaf III[*]

Education, the traditional weapon for fighting unhealthy behaviors, was an abject failure in reducing smoking and obesity. But using legal action—law suits, regulatory proceedings, and legislation—has proven to be overwhelmingly effective in slashing smoking rates in the U.S., and more than ten successful fat law suits suggest it can also be very effective in fighting obesity. Educational messages cannot compete with billion dollar ad campaigns by tobacco and food companies, and cost taxpayers billions. In stark contrast, banning smoking in workplaces and public places has been proven to be the most effective way to get people to quit—yet it costs taxpayers nothing, Also, high taxes on cigarettes, and surcharges for smokers' life and health insurance, are very effective at reducing smoking, and bring in—rather than cost—money. Similarly, requiring the disclosure of calories and trans fats, limiting the size of high-calorie sodas, taxing especially fattening foods, and keeping fast food outlets out of and away from schools, etc. can be far more effective than "eat more vegetables" educational messages.

[*] John F. Banzhaf III is a Professor of Public Interest Law at the George Washington University. He is a FAMRI Dr. William Cahan Distinguished Professor, a Fellow of the World Technology Network, and the founder of Action on Smoking and Health (ASH). Prof. Banzhaf has been called "The Man Behind the Ban on Cigarette Commercials," "The Man Who is Taking Fat to Court," "The Law Professor Who Masterminded Litigation against the Tobacco Industry," "A Driving Force behind the Lawsuits That Have Cost Tobacco Companies Billions of Dollars," "The Lawyer Who's Leading the Battle against Big Fat," "A Major Crusader against Big Tobacco and Now among Those Targeting the Food Industry," and "The Man Big Tobacco and Now Fast Food Love to Hate."

INTRODUCTION

In 1966, the author sent a three-page letter [1] to the Federal Communications Commission (FCC) suggesting that the agency's Fairness Doctrine should be applied to commercials for cigarettes; the most widely advertised product on radio and TV at the time.

The agency agreed, and ruled that all radio and TV stations broadcasting cigarette commercials were required to make available, free of charge, a reasonable amount of broadcast time—generally one antismoking message for every three cigarette commercials—for the other side to be aired.[2]

As a result, hundreds of millions of 1960s dollars worth of antismoking messages were aired for the first time. Although the messages were amateurish, and did not incorporate much that has been learned since then about how to most effectively motivate smokers to quit, the results were nevertheless astonishing.

---

[1] For a copy of the letter. *Available at* http://banzhaf.net/by/FCCFairnessDoctrineComplaint.pdf.
[2] *See* Banzhaf v. F.C.C., 405 F.2d 1082 (DC Cir. 1968); *See* generally Cigaret Foe Banzhaf Sees the *Law as a Tool to Attack Social Ills*, 4(17) WALL STREET JOURNAL 69. *Available at* http://banzhaf.net/about/WSJArticle.pdf; Banzhaf, *Industrial Epidemics: Smoking and Obesity—What You Can Do*, 2(15) ISFIT/2011: INTERNATIONAL STUDENT FESTIVAL IN TRONDHEIM 11 (Norway). *Available at* http://banzhaf.net/by/NorwaySpeechMOD.pdf.

Only a few years earlier, the U.S. Surgeon General had issued a very widely publicized report proving, for the first time, that cigarette smoking causes lung cancer—and lung cancer deaths—among smokers.[3] Despite this widely publicized revelation, smoking continued to climb.

But the author's broadcast antismoking messages did something that the Surgeon General and all the major national health organizations could not do; it caused the first ever decline in cigarette consumption,[4] and eventually led to the ban on cigarette commercials.[5]

At that time, the major national public health organizations did not use legal action as a weapon against smoking. Instead, they relied upon research and educational efforts as their major tools in the battle against America's number one public health problem.

When the author's Fairness Doctrine ruling came under legal attack at the FCC, the author naturally asked these large and powerful organizations[6] to help in its legal defense, especially since the author was fresh out of law school with no legal experience, and the author's law firm was threatening to fire the author because Phillip Morris was its largest client.

These organizations all refused, even though they were reaping the benefits in terms of receiving tens of millions of dollars worth of broadcasting time available free for their antismoking messages—and also getting their names before the public in ways they could never have afforded to do otherwise. It appears that a major reason for their decisions not to help was a refusal to see the value of legal action in the public health area—even when it was right under their noses in a very concrete fashion.

This was not too surprising since the concept of a "public interest lawyer" or "legal activist"—i.e., an attorney who uses law not as a tool to help represent identified clients with specific problems, but rather to represent interests (such as auto safety or environmental protection) which would not otherwise ordinarily be represented in legal proceedings, and to

---

[3] *Smoking and Health: Report of the Advisory Committee of the Surgeon General of the Public Health Service*, (1964). *Available at* http://profiles.nlm.nih.gov/NN/B/B/M/Q/.

[4] *See* Centers for Disease Control and Prevention, *Achievements in Public Health, United States, 1900-1999: Tobacco Use*, 48(43) MMWR 986-993 (1999). Figures 2-7, Annual Adult Per Capita Cigarette Consumption and Major Smoking and Health Events—United States, 1900-1998.

[5] *See* Capital Broadcasting Co. v. Mitchell, 333 F. Supp. 582 (3-Judge, DC 1971); *See* generally *Involved Americans: The Man behind the Ban on Cigarette Commercials*, 3(71) READER'S DIGEST. *Available at* http://banzhaf.net/about/ManBehindTheBanReaders%20Digest.pdf. This Law Professor Might Have Saved More Lives than Any Doctor, Norwalk Reflector. *Available at* http://www.norwalkreflector.com/News/2015/03/28/This-law-professor-might-have-saved-more-lives-than-any-doctor.html (last visited Mar. 27, 2015).

[6] The American Cancer Society (ACS), the American Heart Association (AHA), and the American Lung Association (ALA).

use law to attack social problems such as smoking or obesity—had not yet been established.

Likewise, there were then no "legal action organizations"—public interest organizations which used legal action in the form of litigation in the courts and/or legal actions before agencies as their primary vehicles for seeking change—as we know them today.[7]

As a result, the author formed a new organization, Action on Smoking and Health (ASH).[8] Its immediate goal was to defend and enforce the FCC decision the author had obtained, since broadcasters generally refused to comply until some legal complaints were filed with the FCC, and the ruling itself was under attack by the best lawyers the very powerful tobacco and broadcasting industries could afford.

ASH's long term goal, however, was broader. It was to test and seek to validate the concept that legal action could play an important role in dealing with the many problems of smoking, and that there was room for an organization whose primary function would be utilizing a wide variety of different kinds of legal actions to fight smoking and those who promoted it.

In this sense, ASH—along with the Environmental Defense Fund, which was formed at about the same time—were the first major legal action organizations. Today, of course, there are a bewildering variety of legal action organizations representing a wide array of goals and philosophies.

For more than forty years, ASH and the author have proven that legal action can be very effective against the public health problem of smoking. Indeed, it was able to achieve many victories which could never have been achieved through education and research, or even legislation—even if the organizations opposed to smoking could somehow have succeed in lobbying

---

[7] In this regard, the author is not overlooking the NAACP Legal Defense Fund nor the ACLU. The former, at least at that time, was not primarily engaged in bringing legal actions as an organization. Rather, it served primarily as a vehicle by and though which a small group of largely African American lawyers assisted one another in bringing civil rights actions.
The ACLU naturally used legal action, but that was only because its very goal—defending the Constitution, and especially the First Amendment—obviously required legal action.
However, organizations formed to attack major non-legal social problems and achieve specific public goals—e.g., protecting the environment, fighting against smoking or obesity, seeking to protect children from misleading commercials—did not then exist.

[8] Action on Smoking and Health (ASH) was established in the U.S. in 1967 as an organization exempt from taxation under Section 501(c)(3) of the Internal Revenue Service. Its primary goal was to use legal and other related actions against the many problems of smoking. Subsequently, approximately a dozen organizations with the same name were established in different countries around the world. All took a more activist approach to fighting smoking than traditional health organizations, and many also used legal action. *See* generally ASH's Annual Report for 2010. *Available at* http://banzhaf.net/smoking/ASHAnnualReport2010.htm. Allow Us to Introduce You to ASH and Over 40 Years of Progress for Nonsmokers. *Available at* http://banzhaf.net/smoking/ASH'S%20VICTORIES.html.

against the power of the tobacco industry and many of its allies.

These victories included a ban on radio and TV commercials for cigarettes and also for so-called "little cigars," on the use of cartoon characters in tobacco advertising, and the end of cigarette billboards and the Tobacco Institute—all of which probably could not have been achieved except through legal action, even by lobbying, because of restrictions on legislation imposed by the First Amendment.

Moreover, legal action helped achieve bans on smoking in workplaces and public places in the U.S. (and now going worldwide), a settlement under which cigarette companies were forced to pay a quarter-of-a-TRILLION dollars, prohibitions on smoking in homes and in cars to protect children, and higher charges for health insurance (50% under the U.S.'s Affordable Care Act a/k/a Obamacare)[9] purchased by smokers. While the Constitution does not stand in the way of achieving any of these momentous goals, they would have been virtually impossible to achieve solely through federal, state, or local lobbying.

So, for more than forty years, the author has seen how legal action can be such a powerful tool for public health in the area of smoking.[10] Yet, despite this, most antismoking organizations still do not regularly use legal action to help achieve their goals. Instead, they use money which could be used very efficiently to bring legal actions to instead support and concentrate on public education, even though such programs are notoriously ineffective and efficient.

Having shown that legal action could be such an effective tool and weapon against America's number one public health problem, the author decided to see if legal action could likewise be used against our second most

---

[9] *See* 42 USCS § 300gg: "Fair health insurance premiums
(a) Prohibiting discriminatory premium rates.
(1) In general. With respect to the premium rate charged by a health insurance issuer for health insurance coverage offered in the individual or small group market—
(A) such rate shall vary with respect to the particular plan or coverage involved only by—
(i) whether such plan or coverage covers an individual or family;
(ii) rating area, as established in accordance with paragraph (2);
(iii) age, except that such rate shall not vary by more than 3 to 1 for adults (consistent with section 2707(c) (42 USCS § 300gg-6(c)); and
(iv) tobacco use, except that such rate shall not vary by more than 1.5 to 1; and
(B) such rate shall not vary with respect to the particular plan or coverage involved by any other factor not described in subparagraph (A)."
Note that, "tobacco use" is the only wellness factor specifically singled out for this special treatment. In other words, factors such as obesity, lack of exercise, etc. are not included.

[10] *See* generally Allow Us to Introduce You to Ash and Over 40 Years of Progress for Nonsmokers *Available at* http://banzhaf.net/smoking/ASH'S%20VICTORIES.html. Brief Biographical Statement of Prof. JOHN F. BANZHAF III Related to Smoking. *Available at* http://banzhaf.net/smoking/BanzhafBioSmoking.pdf.

serious and expensive public health problem: obesity. Starting with a law suit against McDonald's in which the author's law students forced the fast food giant to publicly disclose that it added beef fat to its french fries—as well as pay out over $12 million[11]—we have now helped establish a small but growing movement to use legal action as a weapon against obesity.[12]

There have now been almost a dozen successful legal actions (or threats of legal actions) aimed directly or indirectly at obesity,[13] and the U.S. Supreme Court recently opened the door for suits against food companies even wider.[14] But, as with smoking, most of the time, money, effort and other resources aimed at the problem of obesity appear to be concentrated on educational programs rather than legal action.

So, for these reasons, when the author was invited to present a paper at the XXXIVth International Congress on Law and Mental Health in Vienna, the author chose to emphasize the importance and advantages of incorporating legal action in health organizations' arsenal of weapons against both smoking and obesity. The author's presentation, as the author prepared it, follows.

As with any other speech, there were no footnotes, and this was especially true since most of what the author talked about come from the author's own experiences as to which the author had personal knowledge. However, the author has added a very small number of footnotes to the body of this article—the text of the speech—only where absolutely necessary for the reader to understand a concept or to avoid misunderstandings. What follows is the speech the author prepared for this International Congress.

---

[11] *See For Hindus and Vegetarians, Surprise in McDonald's Fries*, NEW YORK TIMES (May 20, 2001). *Available at* http://www.nytimes.com/2001/05/20/us/for-hindus-and-vegetarians-surprise-in-mcdonald-s-fries.html\; *McDonald's to Settle Suits on Beef Tallow in French Fries*, NEW YORK TIMES (March 09, 2002). *Available at* http://www.nytimes.com/2002/03/09/us/mcdonald-s-to-settle-suits-on-beef-tallow-in-french-fries.html.

[12] *See Is Fat the Next Tobacco?*, COVER STORY, FORTUNE MAGAZINE (February 03, 2003). *Available at* http://archive.fortune.com/magazines/fortune/fortune_archive/2003/02/03/336442/index.htm; *See* generally, *Conference to Explore Use of Law to Combat Obesity Epidemic, Public Health Consequences*, ASCRIBE NEWS (May 19, 2003). *Available at* http://banzhaf.net/about/foodcon1.html; *Obesity Fight Heads from Fork to Court*, DETROIT NEWS (December 14, 2003). *Available at* http://banzhaf.net/about/fork2court.html.

[13] *See*, e.g., *Ten Fat Law Suits (Including 2 Threatened Ones) Have Been Successful—While One is Still Pending*. *Available at* http://banzhaf.net/suefat.html; *See* generally, Professor John F. Banzhaf III, *Using Legal Action to Help Fight Obesity*. *Available at* http://banzhaf.net/obesitylinks.html.

[14] *See Supreme Court Upholds Next Wave of Class Actions Virtually Every Major Food Company Now at Risk* (June 12, 2014). *Available at* http://www.prlog.org/12336203-supreme-court-upholds-next-wave-of-class-actions-virtually-every-major-food-company-now-at-risk.html; *Supreme Court Rules Competitors Can Bring Suit against FDA-Regulated Labels* (June 17, 2014). *Available at* http://www.mwe.com/Supreme-Court-Rules-Competitors-Can-Bring-Suit-Against-FDA-Regulated-Labels-06-17-2014/.

I. WHY AND HOW LEGAL ACTION—LAW SUITS, REGULATORY PROCEEDINGS, AND LEGISLATION—HAVE PROVEN TO BE FAR MORE EFFECTIVE AND EFFICIENT AT REDUCING SMOKING THAN EDUCATIONAL PROGRAMS

In 1967, shortly after graduating from law school, and ironically while working on a luxury cruise ship—rather than as a lawyer or law professor—the author filed a 3-page legal action which forced U.S. radio and television stations to make hundreds of millions of 1967 dollars worth of broadcast time available free for messages about the dangers of smoking.

The impact was nothing short of amazing and phenomenal. Indeed, as a direct result, cigarette consumption in the U.S. plummeted for the first time ever.

In other words, the author was able to do what a major governmental report about the deadly dangers of smoking, the first U.S. Surgeon General's Report on Smoking issued three years earlier, and linking smoking for the first time to lung cancer, had not been able to accomplish.

Experts have said that the author's action, in getting so many people to quit, probably saved more lives than any physician then living.

It certainly saved far more lives than any traditional anti-smoking educational campaigns even had; or, indeed, any other governmental or private action to date.

So, having triggered the most successful and effective antismoking educational campaign ever, you might find it strange that, the theme of the author's talk is that educational campaigns are a very INeffective way to fight against unhealthy behaviors like smoking and obesity.

On the other hand, legal action—sometimes summed up in the phrase "SUE THE BASTARDS"[15]—is a far more effective and more efficient way of attacking not just smoking and obesity, but also many other major and very expensive public health problems such as drunken driving, spousal abuse, and the failure of adults to buckle up their kids in cars, etc.

Let the author explain.

For years before the author brought his legal action, public health organizations had tried without any success to get anti-smoking educational

---

[15] *See* generally, *Public Health and the Law—Making New Health Law: "Sue the Bastards"*, 70(10) AMERICAN JOURNAL OF PUBLIC HEALTH 2016 (October 1970). *Available at* http://ajph.aphapublications.org/doi/pdfplus/10.2105/AJPH.60.10.2016. *The Banzhaf Way—Sue the Bastards, Congressional Record*, 144(7) PROCEEDINGS AND DEBATES OF THE 105TH CONGRESS 9820 (May 20, 1998). Frantzich, *Citizen Democracy: Political Activism in a Cynical Age*, at 200: "If that does not work, it's on to one of Banzhaf's favorite strategies, 'Sue the Bastards.' The approach is clear, 'if you can't regulate, litigate!' His license plate even reads 'SUE BAST'."; Law Professor John Banzhaf's "Sue the Bastards" License Plates. *Available at* http://banzhaf.net/docs/SueTheBastardsLicensePlates.html.

messages on the air.

But broadcasters refused to air them, apparently for fear of alienating those selling the most widely advertised product at the time—cigarettes—which were their major advertisers.

And, even if broadcasters had agreed to air antismoking educational messages sponsored by the major health organizations, there is no way they—or even the federal government—could have paid anywhere near the 1.3 billion in today's dollars spent each year on cigarette ads.

The same thing is true today with regard to the problem of obesity.

There is no way health organizations and/or national governments can possibly compete with paid food advertising.

The food and beverage industry spends nearly two billion dollars annually in the U.S. to market foods and beverages—and this just to children and adolescents—many of which are major causes of obesity.

On average, children are exposed to 13 television commercials every day for food alone; and 16 when they become adolescents, primarily for fast foods, sodas, and sugary breakfast cereals.

It's also all too clear, at least with regard to smoking, that educational campaigns are NOT very effective.

Indeed, that's one reason why the U.S. government had to abandon plans to require large so-called graphic health warnings on cigarette packs—a type of massive health education campaign—because, despite the use of such campaigns for many years and in many countries including Canada, there was no proof that they worked; i.e., that they actually reduced smoking.

In short, most educational programs are NOT effective, since they apparently do little to actually reduce smoking and thereby save lives.

Instead, it is now widely recognized that the most effective ways to reduce smoking are: (1) bans on smoking in public places and workplaces, and (2) economic incentives—making smoking more expensive.

Early on, before public smoking was widely banned in U.S., antismoking educational campaigns sponsored by companies did little to reduce smoking among their workers, even if the company also provided free smoking-withdrawal clinics, economic incentives, or other programs to help its workers quit.

But, once companies announced that smoking in the workplace would be banned as of a certain date, smokers—of whom 80-90 percent already want to quit—finally had the necessary incentive, and they quit in droves.

Similarly, every time a state raised taxes on cigarettes, smoking declined—so that tactic was also very effective in reducing smoking.

But—unlike public health educational campaigns which cost tons of

taxpayer dollars for very little if any return, increasing cigarette taxes is also a very efficient way to reduce smoking because its cost is zero; indeed below zero—since a higher tax on cigarettes brings in far more tax dollars, even after allowing for the decline in smoking the tax causes.

Indeed, if you think about it, we all instinctively recognize that public health educational campaigns are both ineffective (because they do not really work) and inefficient (because they provide very little result for every dollar spent—very little bang for the buck).

That's probably why we do not rely on them when the stakes are high.

Consider just a few common and generally accepted examples:

- Educational campaigns do not really persuade people not to drink and drive—so we largely protect ourselves by instead arresting drunk drivers;
- Educational campaigns did not really get parents to buckle up their kids in cars—so we now simply fine those who do not;
- Also, educational campaigns against spousal abuse are much less effective than simply locking up wife beaters.

Thus, what does work both effectively and efficiently regarding major public health problems like smoking and obesity is legal action; using the very scarce resources most health organizations have to "Sue the Bastards"—for example, suing cigarette companies and the makers of sugary soft drinks, and/or using legal action to get the government to act.

Legal action was clearly a major driving force behind the hugely successful antismoking campaign in the U.S. which has slashed tobacco use.

Here are only a few examples:

- getting antismoking messages on the air, and then driving cigarette commercials off the air;
- getting smoking banned in public places and workplaces;
- killing off Joe Camel and other cartoon characters in cigarette ads;
- outlawing cigarette billboards;
- forcing big tobacco to pay over a quarter TRILLION dollars;
- getting nicotine regulated as an addictive drug;
- providing that health insurance companies can charge smokers more than nonsmokers;
- establishing the right of companies not to hire smokers;
- providing that parents who insist upon smoking around their children may lose primary custody in a divorce; and
- banning smoking in apartments and condos when it drifts into other units.

Yes, "Suing the Bastards" works, and works very well, effectively and

efficiently, so the author's message to public health organizations which want to reduce smoking is to take the money you now use—and largely waste—on fancy brochures, and on other expensive educational campaigns, and use it instead to fund hard-hitting legal actions.

II. WHY IT APPEARS THAT LEGAL ACTION CAN, IN A SIMILAR FASHION, PLAY A MAJOR ROLE IN THE WAR AGAINST OBESITY AND BE MORE EFFECTIVE THAN EDUCATIONAL PROGRAMS

Legal action clearly worked for smoking, and it now appears to be also working for the other major public health problem—obesity.

Let the author explain.

When the author's law students filed the first so-called fat law suit, and won over twelve million dollars from Mcdonald's, it ignited a firestorm of publicity—and really focused public attention, for the very first time, on the public health problem of obesity.

For example, the biggest national food conference—the National Food Policy Conference in Washington—which had previously ignored the issue, made it front-page news by staging a debate between the author and the head of the national restaurant association on obesity and fat law suits.

This fat law suit has helped to inspire about a dozen more; all of which have been successful; as well as major conferences and industry programs, about how companies can head off such fat law suits against themselves by changing their products and their advertising and promotion

Indeed, fat law suits have been called the "Next Wave" of class action law suits by corporate attorneys, and inspired Fortune magazine to run a cover story about how fast food could be the next tobacco—in terms of big law suits.

In concrete terms, the movement to use legal action as a weapon against obesity, just as it had been used so successfully as a weapon against smoking, has already helped lead to:

- requirements that major restaurant chains disclose, on the menus and on menu board, the calories in each dish;
- limits on the sale of sugary soft drinks in schools and elsewhere;
- substantial restrictions on food advertising aimed at kids;
- initially, strict limits—and now bans—on unnecessary trans fats;
- higher taxes, in some places, on especially fattening foods;
- and zoning laws to keep fast food outlets away from schools.

In short, legal action can be, and has already been proven to be, a very effective tool against both smoking and obesity; far more effective and

efficient—dollar for dollar—than fancy brochures and other educational programs.

So, if you want to save more lives as well as more dollars, hire more lawyers and fewer art directors!

III. WHY THE STIGMATIZATION OF SMOKING—A BYPRODUCT OF THE WAR TO PROTECT THE RIGHTS OF NONSMOKERS (OFTEN CALLED THE "CLEAN INDOOR AIR MOVEMENT")—HAS PROVEN TO BE SO EFFECTIVE IN HELPING SMOKERS TO QUIT, AND THEREBY SAVING LIVES AND REDUCING THE HUGE COSTS OF SMOKING

The following remarks address issues and concerns raised by a fellow panelist, Prof. Erica Blacksher, an Assistant Professor in the Department of Bioethics and Humanities at the University of Washington, about stigmatizing and de-normalizing unhealthy behaviors**.** Her presentation on this panel was entitled "Stigma, Public Health and Social Justice: The Case of Obesity Prevention." The abstract appears below.[16]

Now, let the author segway to the topic raised his colleague's presentation—the "shaming" and "stigmatizing" of smoking and obesity as techniques for helping people practice healthier behaviors—which she opposes on so-called ethical and moral grounds.

Leaving philosophizing to her, and to those who prefer to deal with important and life-saving topics like smoking and obesity in the abstract, let the author briefly explain just how effective shaming and stigmatizing have been in slashing smoking in the U.S., thereby saving many real lives and many real dollars in the real world.

As previously noted, the non-smokers' rights movement (i.e.,

---

[16] Abstract—Public health has long used policy tools and tactics that aim to de-normalize unhealthy behaviors, from unsafe sexual activities to smoking tobacco. But whether it is ethically acceptable for agents of public health to use tools that arguably stigmatize those they target remains a contentious question.

Using the obesity epidemic as a case study to ground her analysis, Blacksher takes up the question using a framework of social justice that posits two overarching ethical demands: a fair distribution of important social goods (e.g., outcomes such as health or resources such as social determinants) and equal respect and recognition.

Examining several different population-based strategies to obesity reduction, Blacksher argues that approaches that shame and stigmatize those who are overweight and obese transgress a commitment to equal recognition, which among other things prohibits the oppression and marginalization of non-dominant groups.

She extends this analysis to argue further that, such policies may also fail to produce a fair distribution of health (i.e., normal weight), drawing on the example of tobacco cessation policies, which have largely left behind those who are socioeconomically disadvantaged. Public health instead should pursue policies that are based on a commitment to participation, inclusion, and social support.

restricting smoking in many places to protect nonsmokers), which the author's law students and the author started in the early 1970s by getting smoking initially restricted and then totally banned on airplanes—and a movement which has now led to widespread smoking bans in workplaces and public spaces in many countries around the world—is now recognized as the most effective way to reduce smoking by helping nonsmokers quit.

And smoking is clearly a major public health problem, since tobacco kills nearly six million people each year, about 10% of whom are innocent nonsmokers, and costs an estimated $500 billion annually.

In addition to its primary purpose of protecting nonsmokers, the nonsmokers' rights movement also works to help people quit smoking in at least two distinct ways:

First, by making it more difficult to remain a smoker, for example:

- if a workplace bans smoking, or refuses to hire smokers;
- if smokers do not want to lose primary custody rights to their children;
- if one neighbor gets a court order prohibiting his neighbor from smoking in his apartment/condo.

All of this makes it more difficult to remain a smoker.

But, in addition, one other added effect of the nonsmokers' rights movement is to change—actually, and more properly, correct—the image smokers have had of themselves and of other smokers.

For many years, smokers—as a result of being inundated by commercials and other ads for smoking which featured the rugged handsome Marlboro man, and the sexy socialite Virginia Slims lady, as well as images of the suave James Bond and equally attractive female characters smoking as part of the mating ritual—naturally had the impression that smoking also made them suave, sophisticated, socialable, and, above all, sexy and attractive to the opposite gender.

Indeed, it was exactly this kind of social pressure—to fit in, to be accepted, to be seen as socialable and sexually desirable—that leads most teens to begin smoking in the first place.

But every time a smoker sees a no-smoking sign, it's a blunt reminder that these attractive images are deceptive and completely false.

Smoking does not make you suave, sociable, or sexually desirable; instead, it makes you stinky and smelly, and someone other people do not want to be anywhere around.

Some smokers have said such messages make them feel like "social pariahs" —their term—someone other people shun and avoid.

And that it is a major factor in persuading them to quit smoking, just as

the glamorous images were a major factor in persuading them as kids to take up smoking in the first place.

Thus shaming and stigmatizing smoking is just poetic justice; as they say, "Turnabout is Fair Play" for decades of ads seeking to link smoking to sex and sociability.

And this new way of looking at smoking is very effective in the real world in helping real smokers—the great majority of whom already want to quit—to do so; thereby saving millions of lives and billions of dollars. And the author is not alone here; even the U.S. Surgeon General agreed.[17]

This, of course, is the true and ultimate goal, and only real test and measure of major public health movements, even if it's not the primary purpose of—and the main justification for—the nonsmokers' rights movement.

In addition, in many areas where smoking is already banned in most public INdoor areas, activists have been able to go even further and achieve smoking bans in many OUTdoor areas; for example: at parks, beaches, waiting lines, playgrounds, and even some sidewalks and parking lots.

Obviously, claims used to justify most smoking bans, that secondhand tobacco smoke presents health hazards to nearby nonsmokers, are much weaker regarding those and other OUTdoor areas.

So many activists have successfully argued that it is appropriate to ban smoking—even in OUTdoor areas—not just for health reasons, but rather simply so that children will not be unnecessarily exposed to the sight of people smoking, and thereby conclude that smoking is normal and accepted and a proper respected adult behavior.

Some have criticized this argument and practice, calling it "de-normalizing" smoking, or even "de-normalizing" smokers.

But, think about it, we do the same with drinking, gambling, and embarrassing amorous behavior when it occurs in public in the presence of children—apparently without any ethical objections from any so-called ethicists.

For example, in most American cities, you can not walk down the street with an open beer bottle, wine glass, or mixed drink in your hand.

---

[17] *See also The Health Consequences of Smoking—50 Years of Progress*, THE 2014 REPORT OF THE SURGEON GENERAL 31. *Available at* http://www.surgeongeneral.gov/library/reports/50-years-of-progress/#execsumm. "Denormalization and the Tobacco Industry—Underlying the decline (in per capita cigarette consumption) was increasing public understanding of the dangers of cigarette smoking and increasing unacceptability of being a smoker; that is, the social norm around smoking changed from being completely acceptable and woven into day-to-day activities and interactions among people to becoming an increasingly unacceptable behavior."

The restriction is not designed to prevent people from drinking, since they can consume alcoholic beverages in many indoor areas. No, rather its purpose is to avoid unnecessarily exposing young children to the practice, and possibly leading them to try emulating it. The same is true for gambling.

In short, we de-normalize drinking, gambling, and other activities to protect children, not primarily to stop the behaviors.

By the way, the author has never heard anyone protest, or argue on behalf of, the poor innocent victims of the de-normalizing of drinking or gambling or heavy petting by largely prohibiting them in public places, and probably many other behaviors which are frequently limited in public to protect children, but not limited behind closed doors.

The author also doubts that de-normalizing these very common behaviors has ever caused the participants any mental health problems, or been critiqued for causing "oppression" or for "marginalizing" them, as some bioethicists seem to suggest.

The author also has no idea whether de-normalizing these many different behaviors has had any effect in discouraging them generally, just as there apparently is little hard data about de-normalizing smoking.

But we do know that arguments for de-normalizing smoking have been very effective in getting smoking banned in outdoor areas; even though it also increases the shaming and stigmatization smokers tend to feel as a byproduct of smoking bans in indoor areas.[18]

This, in turn, helps them to quit, thereby helping to save millions of lives and billions of dollars in the real world, so it is clearly a very effective public health strategy and tactic.

In short, regardless of abstract philosophical arguments, shaming and stigmatizing smoking is both effective and efficient, which is why it is so widely supported, in the US and abroad, as a byproduct (or unintended additional benefit) of limiting where people may smoke.

This support has obviously not been undercut by the argument that the poor have been left behind to some extent by the antismoking and nonsmokers' rights movements, thereby arguably denying them what some have termed a "fair distribution of health."

Indeed, there are many reasons why smoking—like excessive drinking, using illegal drugs, obesity, refusing to use condoms, and other unhealthy

[18] *See Why the War on Drugs Should Take Cues from Our Battle against Smoking*, WASHINGTON POST (December 30, 2015). "Beginning in 1964, public- health campaigns worked toward the 'denormalization' of smoking, in the words of the 2014 Report of the Surgeon General, 'The Health Consequences of Smoking—50 Years of Progress.'"

behaviors—are more prevalent among the poor.[19] and they have nothing to do with shaming or stigmatization.

Indeed, for a few simple reasons, adverse social pressures—what some call shaming and/or stigmatizing smoking—are less effective in persuading the poor not to smoke in comparison with the effect of adverse social pressure on upper and middle class smokers.[20]

The same is also true, again for a few simple reasons, for antismoking educational campaigns, and even smoking-withdrawal programs. They are simply less effective when applied to the poor.[21]

Fortunately, and for rather obvious reasons, economic incentives, such as:

- higher excise taxes on cigarettes;
- refusing to hire smokers, or to give smoking breaks to workers who

---

[19] Many unhealthy behaviors—like smoking, unhealthy eating, alcohol abuse, use of illegal drugs, failure to use seatbelts or condoms, etc.—are more common among the poor for several reasons:

• Poor and less educated people tend to have less exposure to educational information and messages in newspapers and magazines;

• They often have more difficulty understanding and appreciating dangers which appear to be only statistical or abstract in nature; e.g., lung cancer as compared with physical injuries in car accidents;

• They may also be less able to "individualize" even dangers which they can conceive (e.g., like injuries in car accidents); in other words, they may not fully appreciate how it could happen to them;

• They are more likely to come from non-standard - and perhaps dysfunctional - families, where there was less supervision and control.

[20] Social pressures—especially shaming and stigmatizing—are less effective in reducing unhealthy behaviors like unhealthy eating and abuse of alcohol and illegal drugs among the poor for many reasons:

• There tends to be a much greater tolerance for aberrant or socially-disapproved behavior among the poor;

• The poor and less educated can expect to receive fewer rewards (e.g., jobs, promotions, invitations to social events, etc.) or have other incentives for conforming to social norms regarding less socially accepted behaviors;

• The poor often have to expend more physical, mental, and emotional energy just to get by with limited incomes and keep going;

• Ads for cigarettes, alcohol, etc. are more prevalent in poorer neighborhoods, as are outlets where such products can easily be purchased.

[21] Antismoking educational programs less effective among the poor and less educated for many well understood reasons:

• They tend to have less exposure to health information and educational messages in newspapers and magazines;

• They often have more difficulty understanding and appreciating dangers which appear to be only abstract and "statistical"; lung cancer rather than car accidents;

• They may be less able to "individualize" even dangers which they can conceive - like teenagers;

• They tend to have less access to things which can help them quit like drugs, support groups, professional assistance and support, etc.;

• Smoking tends to be more prevalent in poorer neighborhoods, thus making it harder for those seeking to quit to get away for cues, triggers (e.g., point-of-sale ads), etc., or to find friends who are supporting and understanding.

smoke;

- smoker surcharges on life insurance, and especially on health insurance;
- are very effective in getting smokers to quit, especially the poor.

For example, as one might well expect, an extra dollar-a-pack tax on cigarettes, or a 50% surcharge in health insurance premiums—as the author was able to get under Obamacare—have a much larger impact on reducing smoking among the poor than among the rich, or even the middle class.

Yet, strangely, when increased economic incentives to reduce smoking are proposed, it is often the so-called advocates for the poor who object—fortunately usually unsuccessfully—since these are the very measures which would help the poor to achieve what some call a "fairer distribution of health"—at least with regard to the millions of lives, and the billions of dollars, needlessly lost to smoking.

In short, regardless of abstract philosophical arguments, shaming smokers and stigmatizing smoking are both effective and efficient, which is one reason why this shaming and stigmatization is so widely supported, in the US and abroad, as a byproduct of limiting where people may smoke.

So, in summary, if you really want to reduce unhealthy behaviors like smoking and obesity, and you want something which really works in the real world, and is also very cost effective:

1. Do not rely upon educational campaigns which are not very effective and never very efficient, since they cost huge amounts of taxpayer or charitable donor money, and cannot effectively compete against paid advertising for products like cigarettes, sugary soft drinks, and other especially fattening foods.

2. Instead, think in terms of using the tremendous and largely untapped power of legal action to directly alter unhealthy behaviors through direct regulation, For example, bans, and also by using the social pressures—shaming—which often flow from such regulation, to help make people healthier.

3. Since governments, like people, can become addicted to smoking and fattening foods, at least in the sense of being reluctant to give up the tax dollars, and buck the powerful commercial interests behind them, consider using lawyers to "SUE THE BASTARDS" to get things going.

In short, if you really want to effectively and efficiently fight smoking or obesity, do not hire art directors and educational consultants, and do not be dissuaded from taking effective life-saving action by ethicists, philosophers, and the like. Instead, "SUE THE BASTARDS."

CONCLUSION

As the many examples cited in the author's speech so clearly demonstrate, legal action—especially in the form of filings with agencies and also in courts, in addition to legislation at state and local levels—has been a tremendously powerful weapon against America's number one public health problem: smoking. Early indications are that legal action will be just as important in making a dent in the current epidemic of obesity. It may be too early to tell for sure since it took many years of different kinds of legal action against smoking before some of the major breakthroughs were achieved.

Legal action, for many reasons, is often more effective (i.e., in being able to achieve goals) and almost always more efficient (in terms of doing it at lower cost with fewer resources, i.e., "more bang for the buck") as a tool for changing unhealthy habits like smoking and eating especially-fattening foods—and thereby reducing heart attacks, strokes, etc. and the huge medical costs they impose on the public—than the more traditional remedy of educational messages and educational programs.

Although not covered in the brief speech, it might be appropriate to consider three related issues which could be of concern to readers:

- Why, despite this overwhelming evidence of how important legal action can be, do so many health organizations concentrate, often to the virtual exclusion of legal action, on education rather than "Suing the Bastards"?
- Why, and in what many ways, is legal action so effective?
- Are there still legal actions which can be brought concerning smoking which promise to be equally effective and efficient as those brought to date, or has all of the "low hanging fruit" (in the sense of especially promising legal actions) already been tapped?

A. Why, Despite This Overwhelming Evidence of How Important Legal Action Can be, Do So Many Health Organizations Concentrate, Often to the Virtually Exclusion of Legal Action, on Education Rather Than "Suing the Bastards"?

When, in the mid 1960s, the major national health organizations refused to provide any assistance whatsoever to the author in defending and enforcing the FCC decision which was giving them so much free broadcast time for their antismoking messages, and for the first time turning the tide and actually reducing the incidence of smoking, the major reason seemed clear. Those leading the organizations at that time had grown up, and come up through the ranks, when the only weapons against the major diseases like

polio, viruses, cancer, etc. seemed to be research and education.

After all, you cannot sue a germ, subpoena a virus, or adopt a regulation to limit the growth of cancer. Therefore the idea of using legal action as a tool or weapon against diseases seemed untenable. Indeed, the author was told that, at the time—even though it was then known that smoking, many men-made pollutants, substances like asbestos, etc. contributed to cancer, and therefore might be subject to various types of legal actions—the American Cancer Society (ACS) did not have one single full-time attorney on its staff.

Moreover, one volunteer attorney for ACS who dealt with the author could not even tell the difference between the major federal regulatory agencies. So any chance of getting the major health organizations to assist the author—even after the effectiveness of legal action had been so clearly established, and the threat of losing this major victory was very real—was nil. Tunnel vision, a lack of foresight, and simple mental inertia probably were the major explanations.

But why does this continue to this day? Why do the major national health and other antismoking organizations continue to largely avoid using legal action? Why are most of their budgets spent on education and not legal action? This is true even though they now try to at least file a brief amicus curiae regarding important cases. Tunnel vision, a lack of foresight, and simple mental inertia are no longer viable explanations.

This is especially puzzling when we look at other fields. Many environmental organizations use legal action as a major weapon to protect the environment. If they did not, many of their contributors probably would go elsewhere because they have seen the tremendous value of legal action. Educational campaigns, many donors have found, are far less effective.

The civil rights and women's rights movements also make great use of legal action. The gay rights movement owes many if not most of its recent advances to legal action. Many other movements—liberal, religious, conservative, libertarian, firearms rights, privacy, etc.—also make extensive use of legal action.

Indeed, looking back over the past fifty years, it is clear that legal action has played a very important role in many modern public interest movements. Clearly a major catalyst for the civil rights movement was the famous case of Brown v. Board of Education[22] which led to the Civil Rights Act. Long before there was an Americans with Disabilities Act, there was a Federal Rehabilitation Act, and before that were a pair of cases based upon

[22] Brown v. Board of Education of Topeka, 347 US 483 (1954).

constitutional law and common law.[23]

The author was fortunate enough to start three major public health movements: the modern antismoking movement, the nonsmokers' rights movement, and the anti-obesity movement. The movement to reform broadcasting began with a famous regulatory filing followed up by a law suit, and the decision in that law suit first established standing for many of the legal actions to follow.[24]

Moreover, even though legal action did not initially trigger many other major public interest movements—e.g., the women's rights movements, the gay rights movement, the environmental movement, etc.—it has played a major role—something which the antismoking and public health groups have apparently not yet completely accepted.

So, in conclusion, the reason why public health organizations have not yet embraced legal action, as so many other public interest organizations have, remains somewhat of a mystery. Perhaps it's still tunnel vision, a lack of foresight, and simple mental inertia. Health organizations also may still be reluctant to rock the boat, to be seen as combative or controversial (since many people still have a negative image of law suits and lawyers) rather than as mainstream, or risk possibly alienating either potential large donors or somewhat conservative foundations. It might also include a continuing failure to appreciate how effective and efficient legal action can be in this area—the very problem which the author addressed in his speech.

It may also have something to do with the fact that so many leaders and others with influence regarding major public health organization have little legal training or background. Thus they may feel far more confident planning, executing, reviewing, and otherwise supervising educational program than providing any meaningful oversight or direction for legal activities.

B. Why, and in What Many Ways, is Legal Action So Effective?

It should not be surprising that legal action can be so effective against many different public health and other problems. The legal action itself is often successful, and therefore achieves the substantive goals desired: e.g., getting antismoking messages on the air, banning smoking in public places, prodding food companies to change their advertising and distribution of

---

[23] *See* generally Rooted in Rights—PARC v. Commonwealth of Pennsylvania and Mills v. Board of Education, DC, (December 11, 2013). *Available at* http://www.rootedinrights.org/15321-revision-v1/.

[24] Office of Communication of the United Church of Christ v. FCC, 359 F.2d 994 (1966). *See* generally, McFaddensept, & Everett C. Parker, *Who Won Landmark Fight Over Media Race Bias, Dies at 102*, NEW YORK TIMES (September 18, 1815). *Available at* http://www.nytimes.com/2015/09/19/us/everett-parker-obituary.html.

especially-fattening foods to children, etc.. Indeed, even legal actions which did not win can nevertheless be successful in achieving major goals.[25]

In addition to achieving such substantive goals, legal action is also a very effective way to generate publicity about a public problem, to focus public attention on corporate wrongdoing, to galvanize public pressure and other support, to attract other organizations to lend support, and to serve as a catalyst for legislation—especially by legislators who are looking for new approaches to protectiing the public interest and also furthering their own careers—i.e., "Doing Well By Doing Good."

Also, legal action can have important ancillary effects. Through pre-trial discovery, plaintiffs can gain valuable information and copies of important documents; documents which can be very powerful weapons in future trials as the tobacco documents proved, and/or in promoting legislation. Organizations which undertake legal actions often find that, it is very useful in increasing contributions through their fund raising campaigns since many donors may see legal action as more important, as well as more exciting, than just another public service message or educational campaign. Moreover, litigation frequently has time pressures—e.g., the need to file a responsive pleading by a deadline—which educational campaigns typically do not, and thus may further encourage donors to give "now" rather than putting it off. The same may well apply to foundations.

In short, there are many ways in which legal actions—including those which are completely successful, those which may be successful only in part, and those which may even be lost—can be very effective in many ways in effectively and efficiently helping to achieve a variety of the goals of charitable public health organizations. They can also help provide support for and strengthen the organization itself.

C. Are There Still Legal Actions Which Can be Brought Concering Smoking Which Promise to be Equally Effective and Efficient as Those Brought to Date, or Has All of the "Low Hanging Fruit" (in the Sense of Especially Promising Legal Actions) Already Been Tapped?

Some in the public health movement, asked to consider taking legal

[25] *See*, e.g., Stone v. FCC, 151 U.S. App. D.C. 145, 466 F.2d 316 (1972). This legal challenge—in which the author participated—to the broadcast license of a DC-area TV station for failing to serve the interests of its African American was eventually dismissed.
However, the legal action before the FCC led to the first African Americans appearing on a major television station anywhere in the U.S. in a significant role, to the increased hiring and promotion of Blacks on television, and to more programming directed towards their interests, initially in the District of Columbia, but ultimately around the country.

action against America's number and most expensive public health problem, and faced with a record of victory after victory flowing from legal actions, have nevertheless suggested that this past history of successes does not necessarily help to plan for the future. In somewhat negative terms, they suggest that all of those legal avenues and approaches which might seem likely to be effective have already been tried—i.e., that all the "low handing fruit" (in the sense of especially promising legal actions) has already been harvested.

But this is wrong. There are many very fruitful approaches which could have been brought many years ago but were not. There are also completely new ones created by new products (e.g., e-cigarettes), new findings (e.g., the dangers of "third hand tobacco smoke" [previously called tobacco smoke residue]), new legal avenues waiting to be explored (e.g., under the federal "Family Smoking Prevention and Tobacco Control Act," the international treaty "Framework Convention on Tobacco Control," the international treaty "UN Convention on the Rights of Persons with Disabilities," and others), and even new dangers (e.g., the tendency of e-cigarettes to explode, or for their cartridges to endanger very young children who, attracted by the aroma of fruity e-cigarette nicotine cartridges, are increasingly being rushed to hospital emergency rooms).

The following are just three examples of legal actions directed against smoking which show great promise for being both effective and efficient. They are likely to be effective because they each have a significant chance of success and, if effective, to cause a very significant change. There also appear to be very efficient, since each requires only a small input—i.e., no long expensive trials, pre-trial discovery, lengthy appeals, etc. In short, they each show promise of providing a large bang for the buck; a much bigger bang for far fewer bucks than virtually any health educational campaign.

D. Leveraging HHS Grants

The Department of Health and Human Services (HHS) has spent many millions of taxpayer dollars in the past few years on a single health education campaign related to smoking. The plan was to require cigarette manufacturers to include, on a large percentage of the space on their packs, large so-called graphic images warning about the various dangers of smoking. It was supposed to be very effective because no U.S. smoker could avoid being exposed to such warning messages. It was also supposed to be very efficient because the cigarette companies, and not taxpayers, would

have been forced to bear the costs. However, neither was true—the program was not highly leveraged because it was a complete failure.

More specifically, the U.S. government had to abandon plans to require large so-called graphic health warnings on cigarette packs—a type of massive health education campaign—because, despite the use of such campaigns for many years and in many countries including Canada, there was no proof that they worked; i.e., that they actually reduced smoking.[26]

So, why not try to persuade HHS to do something likely to be far more effective and far more efficient? Each year HHS makes grants in the billions of dollars for health education programs aimed at smoking, and also far more for general health and wellness program. These grants are highly sought, and applicants will go great lengths to obtain them. Many such grant programs already require that applicants meet certain requirements: e.g., those related to protecting against discrimination, providing affirmative action, safeguarding the environment, assisting veterans, etc.

If HHS were to amend its regulations related to such grants to require that applicants have in place comprehensive and effective plans to protect all persons from the deadly dangers of secondhand tobacco smoke by banning all indoor smoking, it would put tremendous pressure on states, cities, counties, towns, hospitals, health care facilities, universities, and others which now do not provide such protection—i.e., to about half the adult population. Indeed, the same would be true even if HHS, instead of actually requiring applicants to have such plans in place, simply provided that institutions which have such plans would be given preference over applicants which do not.

So, a very simple and very promising legal action would be for an antismoking organization to file a legal petition for rulemaking formally proposing that HHS amend its existing rules related to smoking (or even all) health grants to require (or at least give preference to) applicants which have in place a comprehensive and effective plan to protect nonsmokers by prohibiting any indoor smoking.

---

[26] *See* RJ. Reynolds v. United States Food and Drug Administration, 696 F.3d 1205, 25-27 (2012). "FDA has not provided a shred of evidence—much less the 'substantial evidence' required by the APA—showing that, the graphic warnings will 'directly advance' its interest in reducing the number of Americans who smoke …
FDA's Regulatory Impact Analysis ('RIA')14 essentially concedes the agency lacks any evidence showing that, the graphic warnings are likely to reduce smoking rates …
The RIA estimated the new warnings would reduce U.S. smoking rates by a mere 0.088%, Final Rule at 36,721, a number the FDA concedes is 'in general not statistically distinguishable from zero'. *Id.* at 36,776. Indeed, because it had access to 'very small data sets', FDA could not even reject the statistical possibility that the Rule would have no impact on U.S. smoking rates.".

E. Child Abuse Complaints

Another very simple and highly leveraged legal action aimed at smoking, and more specifically aimed at protecting children from exposure to secondhand tobacco smoke (and thereby also strongly encouraging parents to quit smoking), would be to persuade an appropriate medical association[27] in a sympathetic state (Massachusetts is used as an example below) to encourage its members to take appropriate action whenever a child is brought into a hospital emergency room in respiratory distress from exposure to secondhand tobacco smoke.

Such associations should encourage members to file formal complaints of suspected child abuse (or child neglect or reckless endangerment) the same as they would if a child were regularly being subjected to other toxic and/or carcinogenic substances like asbestos or benzene. They should also advise their members that the law apparently requires such action, and that failure to make such reports can result not only in government enforcement proceedings against individual medical practitioners and their hospitals, but also provide the basis for a civil malpractice act.

In this regard, they should stress that most state statutes require reports based upon mere suspicion or reasonable cause to believe, a far lower standard than to a reasonable medical certainty, probable cause, etc. The statutes also provide a shield from civil liability for medical professionals who file such complaints. Thus filing such complaints not only satisfies a legal requirements, the breach of which could otherwise give rise to a variety of legal sanction; it all provides a shield from potential legal liability.

Although the standards which trigger the reporting requirement vary from state to state, Massachusetts provides a good initial example. Massachusetts statutes provide that a physician must report to the authorities for investigation and possible intervention if he or she has "reasonable cause to believe" that a child under 18 is suffering from "serious physical injury" or "maltreatment." The State's Attorney General has determined that, the term "serious physical injury" includes "all but the most negligible or de minimis injuries to children." In one case mere bruises satisfied this minimal requirement. In short, a child rushed to a hospital room in respiratory distress would clearly meet such a low threshold standard. The Attorney General has also ruled that the statutory term "reasonable cause to

[27] For example, the Association of Emergency Physicians (AEP), American College of Emergency Physicians (ACEP), American Academy of Emergency Medicine (AAEM), National Association of EMS Physicians (NAEMSP), Society for Academic Emergency Medicine (SAEM), Society of Emergency Medicine Physician Assistants (SEMPA), Emergency Department Practice Management Association (EDPMA), etc.

believe" means only a "relatively low degree of accuracy," suspicion, suspected, etc.

F. Threat of Medical Malpractice Suits

In many malpractice cases, what the medical professional did or failed to do is not disputed, and it is clear that there was an adverse health outcome as a result. In such situations, the key issue is the relevant standard of care: what would a reasonable and prudent medical practitioner have done? In other words, did the physician fail to live up to a standard of care generally accepted by medical professions for treatment in such situations.

All too often, the judge or jury must try to determine what that standard of care is, usually on the basis of conflicting testimony from competing expert witnesses. Obviously, forcing lay persons to make a medical determination based upon conflicting testimony is not very satisfactory.

For that reason, judges are always happy to find some standard which has been reduced to writing, and which has been generally accepted—e.g., by one or more appropriate prestigious medical bodies. In such situations, courts have a very strong incentive to use it as the standard of care to be applied in deciding whether or not the act in question constituted medical malpractice.

The US Public Health Service's Clinical Practice Guideline for Treating Tobacco Use and Dependence[28] provide that, "every patient who uses tobacco should be offered at least one of (two) treatments." Many major guidelines by other respected medical bodies—e.g., the Agency for Health Care Policy and Research,[29] U.S. Preventive Services Task Force,[30] etc.—also require that smoking patients receive not just warnings but also treatment, including counseling.

However, as the Partnership for Prevention notes, in a report[31] sponsored by the Centers for Disease Control and Prevention, the Robert Wood Johnson Foundation, and the WellPoint Foundation, fewer than 30% of smoking patients receive even the minimal treatment required by the guidelines. The report estimates that this refusal to follow the Guidelines kills more than 40,000 Americans annually.

Since the percentage of smoking patients who receive the minimal treatment mandated by the guidelines seems to be falling (or is at least static)

[28] *Available at* http://www.surgeongeneral.gov/tobacco/treating_treating_tobacco_use.pdf.
[29] 278 (21) JAMA 1759-1766 (December 3, 1997).
[30] *Available at* http://www.ahrq.gov/clinic/uspstf/uspstbac.htm.
[31] *Available at* http://www.prevent.org.

despite the length of time the guidelines have been in effect, the growing awareness of the huge social and economic costs of smoking, and various educational efforts aimed at physicians, many believe more effective action is now necessary.

Even years earlier, the New York City Health Department warned that, "because physician intervention can be so effective, failure to provide optimal counseling and treatment is failure to meet the standard of care—and could be considered malpractice."[32]

Also, just such a proposal for legal actions was recently advanced in an article in a major journal which suggested that physicians—as well as hospitals, medical centers, health insurance companies, etc.—whose refusal to follow the many guidelines was a proximate cause of a death, disability, or illness of which smoking was a substantial factor, should be sued for medical malpractice. The article contained a very complete and thorough analysis of the many legal and medical issues involved.[33]

The article noted that: "The Treating Tobacco Use and Dependence … CPG, sponsored by the US Public Health Service, recommends effective and inexpensive treatments for nicotine addiction, the largest preventable cause of death in the US …. Furthermore, the failure of many doctors and hospitals to deal with tobacco use and dependence raises the question of whether this failure could be considered malpractice, given the Public Health Service guideline's straightforward recommendations, their efficacy in preventing serious disease and cost-effectiveness."

It concluded that "Although each case of medical malpractice depends on a multitude of factors unique to individual cases, a court could have sufficient basis to find that the failure to adequately treat the main cause of preventable disease and death in the US qualifies as a violation of the legal duty that doctors and hospitals owe to patients habituated to tobacco use and dependence."

In summary, then, a third possibility for law-related action directed against the problem of smoking would be for a health organization to encourage, support, and otherwise help to bring about a medical malpractice law suit where a physician has ignored these many major legal guidelines and refused to offer even one treatment, and where that failure was a significant factor in helping to cause the patient to suffer a heart attack, stroke, etc.

---

[32] *City Warns Docs—Help Patients Stop Smoking—or Else*, NEW YORK POST (December 13, 2002).
[33] Randy M. Torrijos, & Stanton A. Glantz, *The US Public Health Service "Treating Tobacco Use and Dependence Clinical Practice Guidelines" as a Legal Standard of Care Tobacco Control*, 15 447-451 (2006). doi:10.1136/tc.2006.016543.

If this approach is criticized as being too severe, especially in the absence of some appropriate notice to doctors, the health organization could send an appropriate warning to relevant physician organizations, major hospitals, treatment centers, health insurance companies, etc. in the state, putting them on notice that such suits may be be filed if physicians continue to put their patients' health and very lives at risk by continuing to refuse to follow established medical guidelines.

It is likely that, should such a law suit be brought, it would cause a revolution by pressuring doctors to begin offering cessation treatment to patients who smoke, with hospitals, medical care centers, and physician insurers also adding to this pressure, in the same way that the Tarasoff decision[34] caused a revolution in the mental health area.

Once the Supreme Court of California held that mental health professionals have a duty to warn or otherwise protect individuals who are being threatened with bodily harm by a patient, many psychologists and psychologists began providing such now-legally-mandated warnings. In exactly the same way, it is anticipated that once a law suit against a physician for refusing to help his patient quit smoking is successful—and perhaps even once such a suit is simply filed—medical professions will likewise begin providing referrals, medication, and/or other smoking cessation treatments.

Such is the tremendous and still largely untapped power of "SUE(ing) THE BASTARDS".

[34] Tarasoff v. Regents of the University of California, 17 Cal. 3d 425, 551 P.2d 334, 131 Cal. Rptr. 14 (Cal. 1976).