Nowhere Left to Hide? The Banishment of Smoking from Public Spaces

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On May 23, smoking in any New York City park, beach, or pedestrian mall — from Van Cortlandt Park in the Bronx to Brighton Beach in Brooklyn — became illegal. The city council passed the ban last fall by a vote of 36 to 12, rejecting a compromise proposal that small areas remain available to people who wanted to smoke. “I think in the future,” the city’s health commissioner, Thomas Farley, said at a public hearing, “we will look back on this time and say ‘How could we have ever tolerated smoking in a park?’”

New York City has often been a bellwether for the passage of public health laws, and there was symbolic significance in the fact that such iconic public spaces as Central Park and the pedestrian plazas of Times Square would be closed to smoking. Yet though the city’s action may prove influential, it was not radical. According to the American Nonsmokers’ Rights Foundation, more than 500 municipalities in the United States have passed some type of law banning smoking in outdoor recreation areas (see table). Such laws have been enacted in 43 states, most of them during the past 10 years.

The elimination of cigarettes from parks, beaches, and other outdoor spaces represents the most recent phase in a trend that began four decades ago, when the demarcation of areas where smoking would be allowed or prohibited emerged as the central point of conflict for tobacco-control efforts. Initial restrictions focused on enclosed spaces where nonsmokers faced prolonged exposure to secondhand smoke. In 1973, the Civil Aeronautics Board required airlines to designate nonsmoking sections of airplanes for domestic flights; similar rules for interstate buses soon followed. Over the next several years, cities began requiring that restaurants set aside seats for nonsmokers. The stated rationale for these early measures was not a paternalistic one — that smokers must abstain for their own good — but rather the protection of nonsmoking bystanders. Strikingly, these early restrictions were implemented in the absence of scientific data that secondhand smoke posed a health threat to nonsmokers. Instead, the measures advanced on the premise that secondhand smoke was unpleasant and annoying.

Epidemiologic research eventually documented associations between exposure to secondhand smoke and a host of health problems, including elevated risks of lung cancer, cardiovascular disease, and acute episodes of asthma; the Environmental Protection Agency classified secondhand smoke as a Class A carcinogen in 1993. As the
scientific basis for restrictions grew, so did the number of places that became off-limits to smoking, including schools, stadiums, convention centers, and private workplaces.

Parks and beaches are increasingly joining this list. As the zones of prohibition are extended from indoor to outdoor spaces, however, the evidence of physical harm to bystanders grows more tenuous. Smoking in partially enclosed outdoor settings such as patio seating areas in restaurants may be hazardous to servers who spend hours there. But air-monitoring studies have shown that health risks to people exposed to secondhand smoke outdoors drop off dramatically when the source of the smoke is more than 2 m away.2 The editor of the journal Tobacco Control dismissed as “flimsy” the evidence that secondhand smoke poses a threat to the health of nonsmokers in most outdoor settings.3 Nevertheless, smoking opponents continue to press their case using a variety of claims, including public health rationales as well as “public nuisance” arguments such as litter abatement.

The arguments put forth at the public hearing on the New York City ban last fall exemplified this mixture of rationales. Health commissioner Farley cited data showing that 57% of New Yorkers had tested positive for cotinine, a marker of exposure to tobacco smoke, even though only 16% of city residents smoked. He also argued that cigarette-related litter accounted for three quarters of all litter on beaches and a third of the litter in parks. This claim — based on the counting of individual items of litter rather than overall volume — was met with skeptical questioning by city council members. Finally, Farley emphasized the importance of protecting children from exposure to adult smokers who would serve as negative role models. “Families,” he said, “should be able to bring their children to parks and beaches knowing that they won’t see others smoking.”1

This frank statement revealed the extent to which denormalizing smoking has become a central prong of antitobacco efforts, both as a way of discouraging initiation of smoking and as a means of pressuring current smokers to quit. Transforming smoking from a desirable behavior that will be imitated to a stigmatized one that will be shunned has motivated such efforts as the push to give movies depicting smoking an “R” rating and cigarette counter-advertising campaigns that depict smoking as a dirty and disgusting habit.

Given the addictive nature of nicotine and the difficulty of quitting smoking, strategies of denormalization raise both pragmatic and ethical concerns. Some tobacco-control experts have questioned whether the denormalization of smoking may have unwanted negative effects on the mental and physical health of smokers but fail to lead them to quit.4 Also relevant are issues of social justice. The decline in U.S. smoking rates since the 1960s has coincided with the development of a sharp gradient along the lines of socioeconomic status. Where as about one fifth of all Americans are smokers, about one third of those with incomes below the federal poverty level smoke. These data are especially pertinent to the question of bans in parks. Since smokers are more likely to be poor and therefore dependent on free public spaces for enjoyment and recreation, refusing to allow them to smoke in those places poses potential problems of fairness.

Antitobacco advocates find themselves at a crossroads. Smoking remains a leading cause of preventable illness and death. After several years in which rates of smoking in the United States have remained stagnant, the most successful policy tools for combating the problem, including taxation, provision of cessation services, and public education campaigns, seem to be producing diminishing returns. Most health professionals agree that an outright prohibition on the sale of cigarettes would be unfeasible and would lead to unwanted consequences such as black markets and the crime that accompanies them.

Yet steadily winnowing the spaces in which smoking is legally allowed may be leading to a kind of de facto prohibition. Smoking bans imposed by states and municipalities have been accompanied by comparable measures in the private sector. Some employers and property owners prohibit smokers from congregating in building doorways; colleges and universities have banned smoking on their campuses; condominiums, apartments, and other multi-unit dwellings have passed require-
ments for smoke-free apartments. As the historian Allan Brandt has noted, smokers may soon have nowhere left to hide. Pressed by a city council member about where he believed people should be allowed to smoke in New York City, Farley responded, “I’m not prepared to answer that.”

In the absence of direct health risks to others, bans on smoking in parks and beaches raise questions about the acceptable limits for government to impose on conduct. In 2008, legal scholar Robert Rabin, the former program director for the Robert Wood Johnson Foundation’s Tobacco Policy Research and Evaluation Program, commented, “We should not lose perspective on the question of how restrictive a society we want to create — that is, how far we want to go in reducing individual autonomy, including what can be perceived as self-destructive behavior.” This question should be central as we pursue the critically important goal of reducing rates of smoking.

Disclosure forms provided by the authors are available with the full text of this article at NEJM.org.

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