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On Lobbies, Liberty, and the Public Good

The issue of personal liberty is often raised by those who seek to defeat governmental attempts to prevent injury and disease. By making a pitch for individual freedom, special-interest lobbies frequently influence legislation and regulations in ways that not only are detrimental to the public good but also *reduce the freedom* of many individuals. A tragic example is provided by the recent history of motorcycle helmet laws in this country.

In 1976, Robertson showed that enactment of motorcycle helmet laws was associated with a 30 per cent reduction in motorcyclist deaths.[1] Ignoring this information as well as other data reflecting the beneficial effect of helmet laws, 27 state legislatures subsequently revoked these same laws, producing an increase in motorcyclist mortality. It was as if scientists, having found a successful treatment for a disease, were impelled to further prove its efficacy by stopping the treatment and allowing the disease to recur.

In an article in the current issue of this Journal, Watson, Zador and Wilks show that when helmet laws are repealed, helmet use drops by about half and motorcyclist deaths increase by 38 per cent.[2] This is consistent with previous evidence that wearing helmets reduces the frequency and severity of head injuries.[3]

Adding to the new and impressive evidence presented by Watson and his colleagues is another paper in this issue, in which Muller demonstrates that one need not even include the staggering but hard-to-measure costs resulting from motorcyclists' *deaths* in order to achieve a cost-benefit relationship highly favorable to motorcycle helmet laws.[4]

Is all of this enough to convince legislators to keep or restore helmet laws? Apparently not. To cite just one example, in February 1980 Maryland's Senate Committee on Constitutional and Public Law voted overwhelmingly not to reinstate the helmet law—despite evidence presented as to the effectiveness of the law, the negative effects (including costs) of repeal, and a poll showing strong voter support for the helmet law. The Committee also reviewed case histories of permanently disabled Maryland motorcyclists, who had received severe head injuries since the repeal while not wearing helmets. The combination of solid data plus the pressure exerted by public health, medical, safety, and youth groups as well as state agencies (transportation, police, medical examiners) was not enough to counterbalance the enormous lobbying effort that had culminated in 1979 in repeal of Maryland's helmet law.

Helmet law opponents, successful now in Maryland and many other states, have included representatives of ABATE (A Brotherhood Against Totalitarian Enactments) and the American Motorcycle Association. While extremely vocal, visible, and effective in their pleas to "let those who ride, decide," they have not represented the viewpoint of the majority of motorcyclists—polls show the majority favor helmet laws[5]—much less the viewpoint of the general public. Yet because of their successful lobbying, this year in the U.S. more than 1,000 motorcyclists will die who other-

wise would have lived. Thousands more will sustain significant nonfatal head injuries, some resulting in permanent impairment.

In the words of John Knowles, "One man's freedom . . . is another man's shackles in taxes and insurance premiums."[6] The general public will share the burden of deaths and injuries in a variety of impersonal ways: by paying for acute and long-term care and rehabilitation, and through increased demands on limited resources, such as blood supplies and emergency services. In more personal ways, the families and friends of the injured motorcyclists will also be affected: in addition to their emotional and financial involvement, they will be called upon to meet the needs for physical care of those disabled, to help their dependents, and to make other commitments that may extend over long periods of time.

Less widely recognized but equally important is the personal cost to the motorists involved in these crashes—the indelible memory of the impact, the feelings of guilt, the possibility of a manslaughter conviction, the potential for financial disaster. A review by Stephen Teret of recent judgments for brain injuries found four cases in which the awards totaled $11 million. "Needless to say, these amounts are in excess of the automobile liability insurance that most of us carry. (Therefore) when a motorcyclist chooses to ride without his helmet, he is not only placing his own head at risk; he is also placing at risk for the other drivers on the road their bank books, their homes, and their children's college education."[7]

The constitutionality of motorcycle helmet laws has been upheld by the highest courts of at least 25 states and no longer would seem to be a real issue, even though the anti-helmet lobby's primary argument continues to be that individual rights are usurped by helmet laws. It is ironic that the motorcyclists' newfound liberty is jeopardizing the rights and liberty of others—even though "liberty," as guaranteed by the Constitution, does not mean that the minority can dominate the majority, or that we have the right to be wholly free of restraint, or that the individual person can use his liberty regardless of injury to others. This was the opinion of the court in the landmark case of *Jacobson v. Massachusetts*, which forms the basis for much of our public health law.[8]

The "individual freedom" argument is neither new nor limited to lobbyists fighting helmet laws. It was used in the past to delay for decades community pasteurization of milk supplies, and it continues to obstruct effective gun control legislation. Noticeably absent from the ranks of the powerful "gun lobby" are the urban poor, who disproportionately suffer the consequences of Americans' freedom to buy handguns and handgun ammunition. Often, lobbyists emphasize the idea of *freedom to* (do something), ignoring the fact that "Victims, on the other hand, want *freedom from* economic hardship, freedom from disease . . ."[9] and freedom from inordinate risk of injury or death.

The issue of personal freedom is often raised by opponents of product safety regulations, including manufacturers of the products in question. People should be free *not* to invest in their own protection, the argument goes—i.e., they should be free to choose unsafe products.[10] If successful in undermining product safety standards, such arguments can mean that the manufacturer is at liberty to sell unsafe products and that the individual purchaser, for all his or her "freedom to choose," has nothing to choose from except the less safe products. A case in point is the self-extinguishing match. Self-extinguishing book matches were developed by the Diamond Match Company in response to the Consumer Product Safety Commission's interest in a standard requiring matches to self-extinguish within a specified period of time that was brief enough to reduce the chance of fabric being ignited by a dropped match. The standard was proposed because dropped matches are a major ignition source for both clothing-related burns, which often result in prolonged hospitalization and severe disability, and housefires, which cause about 5,000 deaths each year in the U.S. Other match companies opposed the self-extinguishing requirement, however, and it was dropped. Diamond's self-extinguishing matches were put on the market, but they cost slightly more than standard book matches. Therefore they sold less well and eventually were no longer available in stores. Consumers were left with no freedom to choose safer matches—even though the increased cost of the safer matches, once mass produced, would have been negligible, especially when compared with the reductions in injuries and property damage that would have followed widespread use of the self-extinguishing match.

Product safety standards initially may add slightly to the cost of a product but eventually can more than pay off in reduced losses. They have been described by Claire Nader as "a form of social control which compel us to pay an ounce of gold to save a pound of gold. Freedom from the damaging effects of auto crashes not only saves money and lives; it also enlarges the freedom to use those dollar savings and psychic savings in other ways, for example, for education, health, recreation . . ."[9]

Freedom not to wear a helmet. Freedom to have a handgun. Freedom to choose unsafe products. Each of these "freedoms" is extolled by special interest groups in pursuit of their own objectives. They ignore the fact that each would entail important *losses* of other people's freedoms. It is long past time for public health professionals to put a stop to these losses, especially when freedom from injury and disease is being sacrificed.

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REFERENCES

1. Robertson LS: An instance of effective legal regulation: Motorcyclist helmet and daytime headlamp laws. Law and Soc Rev 1976; 10:467-477.
2. Watson GS, Zador PL, Wilks A: The repeal of helmet use laws

and increased motorcyclist mortality in the USA—1975-1978. Am J Public Health 1980; 70:579-585.
3. U.S. Department of Transportation, National Highway Traffic Safety Administration: The Effect of Motorcycle Helmet Usage on Head Injuries, and the Effect of Usage Laws on Helmet Wearing Rates—A Preliminary Report. Washington, DC, January 1979.
4. Muller A: Evaluation of the costs and benefits of motorcycle helmet laws. Am J Public Health 1980; 70:586-592.
5. Commonwealth of Pennsylvania: Analysis of the Mandatory Motorcycle Helmet Issue. Harrisburg, PA: Governor's Traffic Safety Council, 1977, p. 302, Appendix E.
6. Wall Street Journal, March 22, 1976, p. 1. IN: Garner DW: Cigarettes and welfare reform. Emory Law J 1977; 26:335.
7. Teret S: Testimony on SB 90 before the Maryland Senate Committee on Constitutional and Public Law. January 15, 1980.
8. Jacobson v. Massachusetts, 197 U.S. 11 (1904).
9. Nader C: Controlling environmental health hazards: Corporate power, individual freedom and social control. IN: Public Control of Environmental Health Hazards, EC Hammond and I Selikoff (eds.), Ann New York Acad Science 1979; 329:213-220.
10. Baker S: Who bought the cars in which people are injured? An exploratory study. Am J Public Health 1969; 69:76-77.

Smoking in the Workplace: A Hazard Ignored

The health effects of tobacco smoking have been debated ever since its introduction into Europe in the 16th century. Some thought tobacco had useful medicinal properties; others considered it "an enemy of the stomach."[1] A French physician associated oral and lip cancers with smoking as long ago as 1859,[2] but a comprehensive review of all the data on smoking and health was not undertaken until 1961 when the U.S. Surgeon General appointed a scientific committee to study the issue. The committee's 1964 report, *Smoking and Health,* concluded that "cigarette smoking is a health hazard of sufficient importance in the United States to warrant remedial action,"[3] and many innovative programs have been implemented during the past decade and a half to inform the public of the harmful effects of cigarette smoking and to reduce the prevalence of smoking.

However, despite some successes in the control of cigarette smoking, it is still recognized as "the single most important preventable cause of death."[4] In 1979 *Smoking and Health* report of the Surgeon General states that the decline in the percentage of adult smokers has not been matched by a decline in the absolute number of cigarette smokers,[5] and HEW Assistant Secretary Julius Richmond hoped the 1979 report would "encourage the medical and public health communities to continue their search for what the Advisory Committee 15 years ago defined as 'appropriate remedial action.' "[6]

As Bennett and Levy point out in their article in this issue of the Journal,[7] the workplace is an important area for continuing "remedial action" by establishing "programs and policies that facilitate smoking cessation," and they indicate the need for greater effort in developing workplace programs to reduce smoking.

The reasons why more smoking cessation programs have not been implemented in the workplace can be found in the Bennett and Levy article itself. First, the authors view smoking cessation as an "approach to prevention of *non*-occupational disease," and second, they feel that "the recent 'life-style' trend in preventive medicine, which puts the burden on the individual to change in order to achieve better health, often does not emphasize that changes must be made in the environment—in this case, the workplace." Like so many others in the medical community, in federal regulatory agencies, in labor, and even in industry, they have failed to recognize the crucial role of smoking in *occupational* health—not just general health—and that control of smoking in the workplace is an *additional* method of occupational environmental control, not a substitute for all other workplace environment changes.

There are extensive epidemiological data verifying the adverse health effects that can result from the interaction between tobacco (cigarette) smoking and exposure to chemical and physical agents in the workplace. In its bulletin *Adverse Health Effects of Smoking and the Occupational Environment,* the National Institute for Occupational Safety and Health (NIOSH) identifies six major ways in which smoking, interacting with agents found in the workplace, affects health.[8] Smoking has been shown to have a role in the evolution of occupational health problems such as chronic pulmonary disease,[9-12] anoxia due to carboxyhemoglobin formation,[13] and cancer.[14-17] The impact of this interaction is particularly severe because more blue collar workers than white collar workers smoke (51 per cent compared to 37 per cent)[18] and it is precisely the blue collar workers who have a greater opportunity for exposure to potentially hazardous physical and chemical agents in the workplace. From all the data now available, there can be no doubt that elimination of smoking in certain occupational settings would significantly reduce disease occurrence in the workplace.

Despite the evidence, the NIOSH position is a rather pallid one—its recommendation being that "the use of and/or carrying of tobacco products into the workplace be curtailed."[19] The Occupational Safety and Health Administration (OSHA) has also been timid about smoking in the workplace, to the point of inaction, even though the "general duty" clause of the Occupational Safety and Health Act of 1970 states in Section 5(a) that:

> "Each employer shall furnish to each of his employees employment and a place of employment which are *free from recognized hazards* that are causing or are likely to cause death or serious physical harm to his employees."

OSHA cannot fulfill its mandate without addressing the issue of the adverse effects of smoking.

Resistance to the control of smoking in the workplace is based in part on the fact that smoking has been an accepted element in Western culture for centuries, and in part on hesitation to interfere with what is considered to be a personal