Stigma and the ethics of public health: Not can we but should we

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A B S T R A C T

In the closing decades of the 20th century, a broadly shared view took hold that the stigmatization of those who were already vulnerable provided the context within which diseases spread, exacerbating morbidity and mortality by erecting barriers between caregivers and those who were sick and by imposing obstacles upon those who would intervene to contain the spread of illness. In this view, it was the responsibility of public health officials to counteract stigma if they were to fulfill their mission to protect the communal health. Furthermore, because stigma imposed unfair burdens on those who were already at social disadvantage, the process of stigmatization implicated the human right to dignity. Hence, to the instrumental reason for seeking to extirpate stigma, was added a moral concern. But is it true that stigmatization always represents a threat to public health? Are there occasions when the mobilization of stigma may effectively reduce the prevalence of behaviors linked to disease and death? And if so, how ought we to think about the human rights issues that are involved?

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Judging stigma

The 1960s witnessed the rise of broad set of oppositional challenges to the established order. The African-American civil rights assault on racism; the new feminist attack on the interpersonal, social, and legal subordination of women; the effort on the part of gay men and lesbians to upend heterosexual domination and the classification of homosexuality as a psychiatric disorder – each represented a potent expression of a deep political and social disaffection. It is within this context that we must understand the powerful impacts of Erving Goffman's *Stigma* (1963) that spoke of individuals who stood as "discredited person[s] facing an unaccepting world" (p. 19).

It was the same broad political and ideological context that gave rise to and amplified the influence of the labeling school of sociology that subjected dominant conceptions of normality to radical criticism. Beginning with the assumption that it was society that created the deviant and deviancy, John Kitsuse (1962) famously stated, "Forms of behavior *per se* do not differentiate deviants from nondeviants. It is the response of the conventional and conforming members of the society who identify and interpret behavior as deviant which sociologically transforms persons into deviants" (p. 248). As a consequence, the labeling school typically took the perspective of the victimized: the drug user, the alcoholic, and the homosexual. While conventional sociological orientations, drawing on a grand tradition that stretched from Durkheim to Merton, sought to understand the root causes of deviance and assumed a "correctional" thrust, the labeling school was "appreciative," implicitly or explicitly challenging those who labeled. David Matza, a central figure in this tradition, thus wrote in 1969, "We do not for a moment wish that we could rid ourselves of deviant phenomena. We are intrigued by them. They are an intrinsic vital part of human society" (p. 17).

Over the next decades, a sprawling literature emerged on the extent to which stigma affected the lives of people with mental illness, drug users, the obese, individuals with sexually transmitted diseases and others suffering

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from clinical conditions indicative of a rupture with social convention. Victimization, the subversion of self-esteem, shame, the desperate need to mask and hide were central elements in the narrative that emerged. My purpose here is not to provide a systematic review of that literature but to underscore the ways in these analyses, in ways subtle and direct, reflected an identification with those who have been the targets of stigmatization.

But careful attention to the experience of individuals whom society sought to discredit made clear that those who were the targets of stigmatization had the capacity to resist such efforts. Renee Anspach coined the term "identity politics" to capture this phenomenon. "Sociological theories have, perhaps unwittingly, subscribed to the mythology of the helplessness of the handicapped and the 'mentally ill.' In one way or another, the social welfare model, labeling theory, and the dramaturgical model of the actor are tacitly infused with commonsense assumptions of the deviant actor as individualistic, passive and powerless…. The politicization of the disabled represents an attempt to wrest definitional control of identity from 'normals'" (Anspach, 1979, p. 768). Jennifer Crocker has also made clear the extent to which at least some of those who are objects of discrediting could resist the burden of prejudice and discrimination. More than a quarter of a century after the publication of *Stigma* she could report that "research, conducted over a time span of more than 20 years, leads to the surprising conclusion that prejudice against members of stigmatized or oppressed groups generally does *not* result in lowered self-esteem for members of those groups" (Crocker & Major, 1989, p. 611). Implicitly such analyses celebrated the capacity for resistance.

But where there was evidence of deleterious impacts on personal dignity the voice of those who studied such burdens was clear. As they mapped the contours of suffering imposed by stigma, social scientists tended to adopt a posture of advocacy that was all the more striking given that the analyses that framed their work could be exceedingly technical, adopting a diction of scientific disengagement. In the discussion of the implications of a study of consequences of stigma for men with dual diagnoses of mental illness and substance abuse, for example, Bruce Link et al. (1997) thus asserted, "The message is simple: Stigma has important effects, effects that remain even when people improve while participating in treatment programs. Health care providers are therefore faced with the challenge of how to address stigma in its own right if they want to maximize the quality of life for those they treat and maintain the benefits of treatment beyond the short term" (p. 187).

At times the language could be bold and impassioned. Thus, for example, after describing the impact of stigma on the self-esteem of people with mental illness, the magnitude of which they had characterized as "startling and disturbing," Link et al. (2001) wrote, "The strength of this association highlights the importance of stigma in the lives of people with mental illness and indicates that it is critical for mental health research and policy to address stigma with fervor" (p. 1625). Finally, at the conclusion of his thorough, systematic, and analytically rigorous review of the effects of stigma on the mental health of lesbian, gay and bisexual populations, Ilan Meyer (2003) endorsed the frankly political challenge of Kitzinger, who warned against a perspective that failed to recognize the source of suffering. "If [psychologists'] aim is to decrease 'stress' and to increase the 'ego strength' of the victim, do they risk forgetting that it is the perpetrator, not the victim, who is the real problem? What political choices are they making in focusing on the problems of the oppressed rather than on the problem of the oppressor?" (p. 692).

AIDS, public health and stigma

Much of the classic literature on stigma emerged from the experience of clinical encounters. As Jennifer Stuber and I have shown in an earlier paper which serves as the foundation for this analysis, it was the AIDS epidemic both domestically and globally that provided the context for the articulation of a strong thesis linking stigmatization and public health (Bayer & Stuber, 2006).

Within the United States, discussions centered on the fact that those who were initially most vulnerable to HIV — gay and bisexual men and drug users — were already stigmatized. Gregory Herek, who came to the study of the stigma of AIDS from his long-standing interest in the stigmatization of homosexuality, early on set the terms for addressing the challenges involved. Not only would he monitor the multiple expressions of stigma, the patterns of discrimination and marginalization, but from the outset he also linked such documentation to proposals for radical remediation. Writing in the *American Psychologist* in 1988, he stressed the importance of protecting confidentiality, enacting anti-discrimination legislation, and launching public education campaigns. It was the responsibility of psychologists to press for such measures. "All psychologists should promote public policy that will deter stigmatization of persons with AIDS. AIDS-related stigma is a problem for all of society. It imposes severe hardships on the people who are its targets, and it ultimately interferes with treating and preventing HIV infection. By attacking AIDS-related stigma, we create a social climate conducive to a rational, effective, and compassionate response to this epidemic" (Herek & Glunt, 1988, p. 890). Writing a decade later, Herek (1999) noted, "The widespread expectation of stigma, combined with actual experiences with prejudice and discrimination, exerts a considerable impact on [people with HIV], their loved ones, and caregivers. It affects many of the choices [they] make about being tested and seeking assistance for their physical, psychological, and social needs… Fearing rejection and mistreatment many…keep their seropositive status a secret" (pp. 1110–1111). Typically, the analyses that followed on Herek's path-breaking discussions stressed the disastrous implications of AIDS-related stigma for the public health. "The profound effects of stigmatization have created an environment in which public health is gravely at risk" (Goldin, 1994, p. 1359). Such concerns were mirrored in statements by U.S. public health officials. Ronald Valdiserri, a director of AIDS initiatives at the Centers for Disease Control and Prevention, thus wrote in 2002, "To underestimate the insidious power of stigma is to risk the very success of effective HIV prevention and care programs…As public health practitioners, it is our

responsibility to work toward minimizing the negative health consequences of HIV/AIDS stigma" (pp. 341–341).

Globally, in nations where HIV was primarily heterosexually transmitted a pattern of stigmatization, discrimination and even violence emerged. Whenever it occurred, the negative consequences for AIDS prevention efforts were predictable. Stigma also functioned to buttress the social subordination of those who were already marginalized (Parker & Aggleton, 2003, p. 13). Concern that the dominance of a social-psychological perspective had tended to mask the social-structural core of stigmatization and had diverted scrutiny from the political analysis of who had the capacity to stigmatize led some to argue that a fundamental ideological shift was necessary. "To move beyond the limitations of current thinking in this area," wrote Richard Parker and Peter Aggleton, "we need to reframe our understandings of stigmatization and discrimination to conceptualize them as social processes that can only be understood in relation to broader notions of *power* and *domination*. In our view, stigma plays a key role in producing and reproducing relations of power and control. It causes some groups to be devalued and others to feel that they are superior in some way. Ultimately, therefore, stigma is linked to the workings of *social inequality* and to properly understand issues of stigmatization and discrimination, whether in relation to HIV and AIDS or any other issue, requires us to think more broadly about how some individuals and groups come to be socially excluded, and about the forces that create and reinforce exclusion in different settings" (p. 16). Such a political analysis demanded radical political action. "Ultimately, together with a new emphasis on community mobilization aimed at unleashing resistance to stigmatization and discrimination, structural interventions aimed at developing a rights-based approach to reducing HIV and AIDS-related stigmatization and discrimination should be a high priority in order to create a transformed social climate in which stigmatization and discrimination themselves will no longer be tolerated" (Parker & Aggleton, 2003, p. 22).

Speaking before the UN General Assembly in 1987, Jonathan Mann, Director of the World Health Organization's Global Program on AIDS, underscored the significance of stigma and the social and political unwillingness to face the epidemic as being "as central to the global AIDS challenge as the disease itself" (as cited in Parker & Aggleton, 2003, p. 13). A year later the world summit of health ministers adopted a declaration (as did the World Health Assembly) that underscored the obligation of governments to protect people with HIV from stigmatization. There was a need, said the declaration, to protect human rights and human dignity. Discrimination against, and stigmatization of HIV infected people and people with AIDS, undermined public health. It was a matter of urgency that they be avoided. At the beginning of the 21st century the persistence of stigma and the need to confront it remained central concerns of international public health. Peter Piot, director of the Joint United Nations Program on HIV/AIDS, asserted that the "effort to combat stigma" was at the top of his list of "the five most pressing items on [the] agenda for the world community" (Parker & Aggleton, 2003, p. 14). The Declaration of Commitment adopted by the UN

General Assembly Special Session on HIV/AIDS in June 2001 pledged all signatory states to "develop strategies to combat stigma and social exclusion connected with the epidemic" (as cited in de Bruyn, 2002, p. 9).

Human rights thus became central to the diction of framing the understanding of and response to the global epidemic. Drawing on years of experience, Mann and his colleague Daniel Tarantola pressed this point repeatedly. "Those who – before the arrival of HIV/AIDS – were societally marginalized, stigmatized or discriminated against, were found gradually and increasingly to bear the brunt of the HIV/AIDS epidemic…human rights violations are now recognized to be primordial *root causes* of vulnerability to the epidemic" (Mann & Tarantola, 1998, pp. 4–5).

Just as they would come to use the experience of AIDS to frame a doctrine about the relationship between health and human rights, those who were committed to combating stigma would use their vantage to look back on the history of epidemic disease. In the United States, when they did so they would, as Amy Fairchild has noted, encounter a complex series of socio-political narratives (Fairchild, personal communication, March 12, 2007). They would read these through the lens of their urgent contemporary concerns.

With the rise of public health as a profession in the 19th century and increasingly systematic state action to prevent and control infectious disease, the stigmatization of particular races and classes became a consistent byproduct of efforts to intervene. Former slaves, Italians, Jews, the Chinese, and Mexicans were blamed for diseases such as typhus, tuberculosis, and smallpox, and all experienced both the heavy hand of public health and the social and economic consequences of being identified as vectors of contagion (Abel, 2007; Hunter, 1997; Kraut, 1994; Markel, 1997; Shah, 2001). In 1850, Lemuel Shattuck, the renowned Massachusetts sanitary reformer, not only identified crowding, impure air and water, poor sewerage and drainage, and dirt as critical causes of sickness and death. He also believed that disease was the penalty for immorality. In Boston, a third of the population were immigrants. Shattuck argued that they "render[ed] the air very impure, and expose the lives of infants, who are compelled to breathe it, to disease and death" (Rosenkrantz, 1972, p. 19).

Quarantine, a central feature of responses to epidemic threats, was suffused with stigmatization, so much so that David Musto has argued that it represented, "far more than the mere 'marking off or creation of a boundary to ward off a feared biological contaminant lest it penetrate a healthy population…When an epidemic illness hits hardest at the lowest social classes or other fringe groups, it provides that grain of sand on which the pearl of moralism can form" (as cited in Markel, 1997, p. 4).

Health officials were not, however, univocal in their perspectives on stigma. Some authorities explicitly recognized stigma as a problem to be overcome. For example, when health officials began to press for venereal disease surveillance in the second decade of the 20th century, they took cognizance of the moral opprobrium that surrounded sexually transmitted conditions, the "stigma [placed] upon the moral character of the person involved" (Biggs, 1913, p. 144). Likewise, in the instance of tuberculosis, health officials advised that patients protect themselves from the

possible stigmatizing effects of their condition and told them to carefully guard knowledge of their condition. "Do not talk to anyone about your disease, except your physician," the New York city health department warned patients in its widely distributed informational circular published in a number of languages and given to all registered tuberculosis patients (New York City Health Department, 1912, p. 61).

In other instance, stigma was viewed as serving as a useful tool. Although it contradicted other aspects of his campaign against venereal disease, Surgeon General Thomas Parran, in the 1930s, "advocated that 'syphilis ignorance' be replaced with 'syphilophobia,'" arguing that the fear of syphilis "never killed anyone…never brought a handicapped child into the world, never infected an innocent person" (as cited in Brandt, 1987, p. 155). And proponents of vaccination sought to use shame to persuade parents to have their children immunized. In 1926, for example, a representative from the American Child Health Association eagerly anticipated "The time…when every case of diphtheria will be an indictment against the intelligence of parents" (as cited in Colgrove, 2006, p. 98).

If, historically, complex and sometimes contradictory perspectives on stigma have characterized the approach of public health officials, many contemporary historians – who, like students of social deviance, tend to identify with history's victims – have been drawn to dark interpretations of public health interventions. As Nancy Tomes has trenchantly argued, "Social historians have tended to treat the expressed concern about disease prevention as a rationalization for some other…objective such as reinforcing gender roles, class differences, or ethnic prejudices" (Tomes, 1990, p. 512). It was this historiography that contemporary opponents of stigma called on as they sought to buttress their argument about the pedigree of what needed to be done in the future. "Historical examples abound of stigma interfering with effective collective response to diseases ranging from cholera to syphilis. In all of these cases, the social construction of the illness incorporated moral judgments about the circumstances in which it was contracted as well as preexisting hostility toward the groups perceived to be most affected by it. Such constructions can contribute substantially to the social risk and felt stigma associated with a disease and, consequently, influence the behavior of individuals at risk for contracting it" (Herek, Capitanio, & Widaman, 2003, p. 538).

Thus, what was learned from syphilis and tuberculosis at the beginning of the century, and AIDS at the end, had implications that were far broader. Writing some years after he had left WHO, Jonathan Mann drew a conclusion about the need to fight stigma to advance the goals of the global public health agenda. Indeed, it became Mann's central mission to demonstrate how public health and human rights were inextricably linked. Writing in the inaugural issue of the journal *Health and Human Rights* he said: "The evolving HIV/AIDS pandemic has shown a consistent pattern through which discrimination, marginalization, stigmatization and more generally a lack of respect for the human rights and dignity of individuals and groups heightens their vulnerability to being exposed to HIV. In this regard, HIV/AIDS may be illustrative of a more general phenomenon in which individual and population vulnerability to disease, disability and premature death is linked to the status of respect for human rights and dignity" (Mann et al., 1994, pp. 20–21).

In a posthumously published article marking the 15th anniversary of the Universal Declaration of Human Rights, Mann focused on the relationship between dignity and health. "Future health professionals may look back at the current limited and narrow understanding of health and wonder how we could have missed seeing violations of dignity as sources of injury to well-being. How could we have missed seeing methods of strengthening dignity as therapeutic avenues? Dignity's meaning in the universe of human suffering may be as evident in the future as the role of HIV in causing AIDS is today" (Mann, 1998, p. 37). Echoing these views and paying homage to Mann, who had died in a tragic plane crash, Gregory Herek (2002) said bluntly, "Stigma and discrimination are the enemies of public health" (p. 604).

Smoking and public health: an exception to the doctrine on stigma?

Against the backdrop of the discussion of stigma, AIDS, and human rights, the course of anti-tobacco advocacy and policy in the U. S. seems all the more striking. In contrast to the HIV epidemic, where those who were infected were seen as blameless, those who smoked would become the targets of public health policies that at first inadvertently but then explicitly sought to utilize the power of denormalization and marginalization to reduce tobacco consumption. Just as the tobacco industry would, over the course of several decades, become the object of increasingly harsh denunciation because it was the purveyor of a toxic product and manipulation, smokers would become the objects of concern because their behavior imposed burdens on others. However, much they themselves would come to be seen as needing the paternalistic ministration of public health, their increasing marginalization would never evoke the protective moral passion that so marked the response to people with HIV.

Tobacco consumption accounts for close to 400,000 deaths a year in the United States. Globally, nearly 5 million deaths a year are attributed to cigarette smoking. By any measure tobacco associated morbidity is a grave public health threat. The 1964 U. S. Surgeon General's report on smoking and health, a watershed in American public health, was issued at a moment when tobacco consumption was ubiquitous. In the United States, 50% of men and 35% of women smoked. Halting campaigns against the tobacco industry emerged, and those who smoked were warned weakly about the dangers of cigarettes. Some limits were imposed on advertising (McAuliffe, 1988). But it was the gradual framing by anti-smoking activists of smoking as an environmental health issue, even when scientific evidence was far from definitive, that began to transform the social context of smoking as normal adult behavior (Bayer & Colgrove, 2004). By the end of the 1970s evidence began to mount that smoking was increasingly being viewed as undesirable by significant proportions of non-smokers. "In addition to being seen as harmful to health," two social

scientists noted in 1979, "smoking came to be seen as undesirable, deviant behavior, and smokers as social misfits. In fact data now show that people increasingly view smoking as socially reprehensible" (Markle & Troyer, p. 617).

Research suggesting that passive smoking increased the risk of heart disease and cancer made it possible for anti-tobacco advocates to assert that, like drunk drivers, those who smoked in public were culpable for the deaths of innocents. To confront such malefactors, some believed, anything that might reduce smoking had to be considered, even heavy-handed moral opprobrium. "What we need is a national campaign that results in the stigmatization rather than the glorification of the smoker," a psychiatrist wrote to the *New York Times*. "This, in my opinion, would be the most effective way of reducing the number of smokers and confining their smoke to the privacy of their homes" (Gardner, 1977, A13). With all of the resonances involved, parents who smoked in the presence of their children would, on occasion, be accused of abuse and neglect (Clark, 2002).

Responding to changing public attitudes, local lawmakers throughout the country began to impose restrictions on where smoking could occur. By the mid-1980s, 80% of the U. S. population lived in states where some limits on public smoking had been imposed (U. S. Department of Health and Human Services, 1986). Joseph Califano, former Secretary of the U.S. Department of Health, Education, and Welfare, gave voice, if in a hyperbolic manner, to the emerging mood that provided the impetus for such efforts. Cigarette smoking, he asserted, was "America's top contagious killer disease. …Cigarette smoking is slow motion suicide. It is tragic when people do it to themselves, but it is inexcusable to allow smokers to commit slow-motion murder" (Califano, Jr., 1985). In an editorial commenting on research implicating passive smoke in the deaths of non-smoking spouses, the *New York Times* wrote of "Smoking Your Wife to Death" ("Smoking Your Wife," 1981).

As smoking rates declined in the 1980s and 1990s, and more importantly as the social class composition of smokers underwent a dramatic shift downward – those with more education were quitting, while those at the bottom of the social ladder continued to smoke – states with more aggressive anti-smoking campaigns moved beyond a focus on the deleterious consequences of public smoking for non-smokers. Drawing on Norbert Ellias' classic social history of manners and public behavior, *The Civilizing Process*, Robert Kagan and Jerome Skolnick (1993) noted in the early 1990s that while "smoking has not yet, like blowing one's nose in one's hands, or spitting, or eating with the fingers, been stigmatized as 'disgusting'…when smokers are *segregated* a powerful message is conveyed: their conduct has formally been recognized to be so harmful that it defiles others…Smokers…now often encounter *some* legally segregated places…further relegating [them] to the demeaning social territory of the deviant and faintly unrespectable" (pp. 85, 87).

Confronted with massive advertising and promotion campaigns that linked cigarettes to athletic prowess, social success, and sexual attraction, public health officials needed a powerful counterweight. And so, in the last years of 20th century, states, pressed by anti-smoking activists,

began to embrace a strategy of denormalization that, whether intentionally or inadvertently, would provide fertile ground for a stigmatization that would at once discourage new smokers and prod those who smoked into giving up their toxic habit. The absence of a rights-based opposition to this trend (except from the tobacco industry and its surrogates), given the broader discussion of stigma and public health, is striking.

The Massachusetts tobacco control program noted, "Norms that allow smokers to smoke in most venues, including while at work or *home*, provide little incentive to quit" (Commonwealth of Massachusetts Department of Public Health, emphasis provided). Florida's tobacco control efforts sought to "deglamorize" smoking and viewed as a mark of their impact the extent to which students were "less likely to buy into the allure of tobacco" (Bauer, Johnson, Hopkins, & Brooks, 2000, p. 726). And California's campaign to "denormalize" tobacco consumption sought "to push tobacco use out of the charmed circle of normal, desirable practice to being an abnormal practice" (California Department of Health Services, 1998, p. 3). Lauding the efforts of the California Health Department, Gilpin, Lee, and Pierce (2004) embraced the force of social conformity noting, "In a society where smoking is not viewed as an acceptable activity, fewer people will smoke, and as fewer people smoke, smoking will become ever more marginalized" (p. 38).

The embrace of a strategy of denormalization by public health officials and anti-tobacco activists was not mere moralism. Just as instrumental considerations had informed the opposition to AIDS-related stigma, they now shaped efforts to marginalize and denormalize smoking and smokers. These efforts have been fueled by a still nascent, but growing, body of evidence that the stigmatization of smoking has, in fact, had an impact on smoking behavior. One study noted in 2003, "Cigarette smoking is not simply an unhealthy behavior. Smoking is now considered a deviant behavior…[smokers] are stigmatized" (Kim & Shanahan, 2003, p. 349). Such stigmatization, the authors conclude, "may have been partly responsible for the decrease in the smoking population"(Kim & Shanahan, 2003, p. 360).

Underscoring the extent to which several decades of tobacco control efforts had set the stage for contemporary strategies that might employ the power of stigmatization, the advocacy group Americans for Non-Smokers' Rights noted that tobacco control advocates had stumbled onto the best strategy for reducing tobacco consumption, "encouraging society to view tobacco use as an undesirable and antisocial behavior" (Americans for Nonsmokers' Rights, 2003). Finally, and indicative of the extent to which those committed to the reduction of tobacco-related morbidity and mortality have explicitly embraced a strategy of marginalization and stigmatization, was a 2006 report in the *American Journal of Public Health* titled, "Effect of Increased Social Unacceptability of Cigarette Smoking on Reduction in Cigarette Consumption." After noting that increasing the social unacceptability of smoking – defined in terms of smoking in restaurants, bars and homes – was as effective in reducing tobacco use as tax-induced increases in prices, the authors state, "Our results indicate that

increasing the social unacceptability of smoking is a highly effective policy tool in reducing consumption. Tobacco control programs should stress the dangers of environmental tobacco smoke and reinforce the nonsmoking norm" (Alamar & Glantz, 2006, p. 1362).

It is the recognition that efforts to denormalize, marginalize and stigmatize smoking can further the goals of public health that makes the contemporary history of tobacco control so critical. If assumptions about how stigmatization is inimical to the goals of public health are, at least in some circumstances, untrue; if stigmatization could be instrumental to changing patterns of behavior that are pathogenic – an idea not foreign to the history of public health – then it becomes necessary to ask a previously unthinkable question: Is it morally acceptable to embrace or foster stigmatization if in so doing we reduce the burdens of disease and premature mortality? Should rights-based considerations trump the utilitarian calculus that is so central to public health analysis? And if not, why not?

Toward an ethics of stigma

In liberal societies it is appropriate, sometimes obligatory, for government to use its coercive powers to affect behaviors of individuals that are injurious to the health and well-being of others. Laws that prohibit, punishment that seeks its impact by the force of specific or general deterrence, and fines that exact economic pain may be called on to limit threats to the commonweal, the choice of sanctions depending on considerations of proportionality and the costs of enforcement. More controversial is the extent to which the state may employ its powers to discourage or prohibit behaviors that have as their central consequence a heightened risk to those who themselves engage in such acts.

Joel Feinberg captured the "repugnance" evoked by paternalism for many in the liberal tradition when he wrote that such measures were "arrogant" and demeaning. They said "in effect that there are sharp limits to my right to govern myself even within the wholly self-regarding sphere, that others may intervene even against my protests to 'correct' my choices and then (worst of all) justify their interference on the ground (how patronizing!) that they know my own good better than I know it myself" (Feinberg, 1986, p. 23). Within the context of American political culture, with its strong emphasis on individualism, such principled opposition to paternalism has found deep resonances. Nevertheless, paternalism is part of the warp and woof of public health where utilitarian values are hegemonic.

Health education campaigns employing a range of persuasive strategies, including social marketing efforts that draw on the manipulative repertoire of commercial advertising, are routine and pervasive. Such efforts not uncommonly have had as their goal the marginalization of behaviors thought harmful. But more restrictive measures, including behavioral mandates or prohibitions, taxes that increase the cost of consuming certain products, and fines that punish, are routine, despite the opposition of libertarians who routinely invoke the language and spirit of John Stuart Mill's *On Liberty*. "We do not," has written Robert Goodin (1989) "leave it to the discretion of consumers, however well-informed, whether or not to drink grossly polluted water, ingest grossly contaminated foods, or inject grossly dangerous drugs. We simply prohibit such things, on grounds of public health…[The] fundamental point is to promote the well-being of people who might otherwise be inclined cavalierly to court certain sorts of diseases" (pp. 30–31).

Profound disagreements over the scope and legitimacy of paternalism have important implications for the discussion of the ethics of stigma. To the extent that paternalistic goals are suspect, then any intervention designed to achieve such ends will provoke opposition. But how should we think about stigma when the goal is to limit other-regarding harms or when some paternalistic measures are viewed as integral to the ethics and practice of public health?

If the state may legitimately shape or control behaviors that increase the risk of disease and death by the exercise of explicitly coercive measures, if it can undertake health promotion campaigns that seek to change social norms and individual preferences, even desires, should it be permitted to adopt strategies that will incidentally but *unavoidably* stigmatize behaviors that pose a threat to the public health? May it engage in efforts that have as their *intended* goal the stigmatization of such behaviors through campaigns that attempt to tap the power of shame and guilt to affect social norms?

In the rare circumstances when these questions have been touched on, they have evoked responses reflective of the long-standing assumptions regarding the pathogenic and all-encompassing consequences of stigmatization. A focus on the link between individual behavior and health, wrote Marshall Becker, had produced a "new morality." "'Being ill' is redefined as 'being guilty.' The obese are stigmatized as 'letting themselves go.' Smokers 'have no will power…We often employ 'guilt' as a motivator, ignoring the fact that guilt itself has considerable potential for creating physical and emotional illness" (Becker, 1993, p. 4). Concerned about how health promotion campaigns designed to discourage behaviors linked to ill health could impose new burdens, Nurit Guttman and Charles Salmon (2004) asserted, "Once stereotypes and stigma are established, they can result in individuals being feared, avoided, regarded as deviant, and even blamed for engaging in the immoral behaviors that must have elicited the 'punishment' of their affliction…This type of social climate can be devastating to members of vulnerable populations who suffer from stigmatized medical conditions since it can result in the internalization of self-blame and destruction of self-esteem" (p. 547).

A much deeper engagement in the issues of shame and stigma has been the subject of an important recent decade long debate among those who have addressed the moral foundations of the criminal law. And while there are critically important distinctions between criminal law and the functions and practice of public health, the encounter sheds light on the questions with which we are concerned.

At the end of the 1980s, John Braithwaite challenged what he saw as a liberal conventional wisdom: that shaming was inimical to the effective use of the criminal law and counterproductive to appropriate social control. Drunk

driving, he argued, was difficult to eliminate because it did "not attract the shame one would expect in proportion to the harm it does because most adults, who have themselves engaged in the offense, suffer discomfort in construing the behavior shameful" (Braithwaite, 1989, p. 166). Shame appropriately deployed, he went on to assert, was not only effective but morally superior to punishments that were degrading. And it was here that Braithwaite made his most intriguing observation, distinguishing between stigmatization that served to turn the offender into an outcast and shaming that held out the prospects for reintegration. "The theory of reintegrative shaming," wrote Braithwaite, "implies that, rather than be tolerant and understanding, we should be intolerant and understanding…maintaining bonds of communication, affection and respect…rather than stigma" (p. 166).

Dan Kahan, too, sought to break with conventional liberal thinking in confronting the role of disgust and shaming. While acknowledging that the former had commonly been put in the service of "socially conservative defenses of public morals offenses," he believed it possible to "redeem disgust in the eyes of those who value equality, solidarity, and other progressive values" (Kahan, 2000, p. 63). Citing the example of enhanced penalties for hate crimes, he noted that those who were low in social status commonly sought to "appropriate rather than annihilate the idiom of disgust" (Kahan, 1998, p. 1633). For Kahan, the question was not "whether a society should organize itself around emphatic ideas of high and low, worthy and worthless, but only what the content of those animating hierarchies will be" (Kahan, 1998, p. 1633).

It was Kahan's deep interest in the role of disgust that, in part, explained his effort to reconsider the role of shame and shaming in the criminal law. He sought to demonstrate that shaming "would likely deter and incapacitate as or nearly as well as short terms of incarceration without imposing nearly so much cost on society or suffering on offenders" (Kahan, 2006, p. 6). Shaming was then less problematic than imprisonment. Despite his persistence, Kahan would come to acknowledge after a decade that he had failed to persuade those who had opposed the use of shame because of how it threatened central values of contemporary liberalism.

Among his sharpest critics was Martha Nussbaum, whose rejection of the effort to call on the force of shame and disgust bore a strong resemblance to the human rights-based attack on stigma in public health. While she challenged Kahan's empirical assertions about who could shame whom and with what bearing on crime and the experience of the socially vulnerable, the heart of her argument centered on the question of dignity. "There is surely something indecent about the idea that a liberal society, one built upon ideas of human dignity and equality, and respect for the individual" would denigrate groups through the power of shame (Nussbaum, 2004, p. 232). Nussbaum recognized that stigmatization within society would not vanish. But for the state to participate in this humiliation was subversive to the values of liberal society (Nussbaum, 2004, p. 232).

Nussbaum was less severe in her analysis of Braithwaite's proposals to incorporate shaming into the criminal law because of the extraordinary lengths to which

he had gone in trying to distinguish between the limited use of shame and the corrupting force of stigma. Nevertheless, she raised a cautionary claim about whether shame once unloosed in the domain of law and public policy could be so easily tamed.

Debates within the criminal law and the question of whether shame should ever be used in public health policy, in important ways, depend on how broadly or narrowly we understand the concept of stigma. Like Nussbaum and Braithwaite, Herek has argued, in writing about AIDS, that stigma must involve an *enduring* condition or attribute that "engulfs the entire identity of the person…[and] does not entail social disapproval of merely one aspect of an individual…The attribute is understood by all to signify that its bearer is a criminal, villain, or otherwise deserving of social ostracism, infamy, shame, and condemnation" (Herek, 2004, p. 14). In so characterizing the essential features and burdens of stigma, he shares the view of others who warn against so broadening the use of the term that it looses its bite. Not all feelings of shame for rule-breaking should be thought of as the consequence of stigma, Sharon Schwartz has argued. "We must," she has said, "keep our terms from being ritualized or trivialized" (Schwartz, personal communication, September 29, 2006). In marked contrast, Bruce Link and Jo Phelan have provided a conceptual analysis that underscores the utility of a less stringent approach. "Stigma exists as a matter of degree…The strength of the connection between labels and undesirable attributes can be relatively strong or relatively weak. The degree of separation into groups of 'us' and 'them' can be more or less complete, and finally the extent of status loss and discrimination can vary. This means that some groups are more stigmatized than others" (Link & Phelan, 2001, p. 377). The normative implications of these alternative definitional perspectives are clear.

In one of the few prior attempts to seriously consider the moral questions posed by the use of stigma to promote the public health – what he sardonically terms "good stigma" – Scott Burris (2002) has said "Stigma can without exaggeration be considered a barbarous and unacceptable form of regulation that a humane society must reject" (p. 187). While explicitly sidestepping the issue of whether stigma met the definition of cruel and unusual punishment under the Eighth Amendment to the U. S. Constitution, Burris made clear the extent to which he viewed stigma as degrading and inhumane by invoking the language of a 1958 Supreme Court decision bearing on the effort to strip a person of his citizenship. "There may be involved no physical mistreatment, no primitive torture. There is instead the total destruction of the individual's status in organized society. It is a form of punishment more primitive than torture" (as cited in Burris, 2002, p. 187). Despite his sharp denunciation of a stigmatization that was so dehumanizing, Burris did not consider it inappropriate for public health to label behaviors like smoking, unsafe sex, and overeating as unhealthy or "bad." Nor did he object to the use of state power "to prohibit, burden, or discourage unhealthy behaviors" (Burris, 2002, p. 188).

If we adopt a strict conception, one in which stigma not only burdens but dehumanizes, not even the most thoroughgoing of utilitarians would find it easy to justify its

inclusion in the armamentarium of public health regardless of whether the goal was to protect people from harming others or themselves. To acknowledge the legitimate exercise of state power to prevent other-regarding or self-regarding harms is not to forego limits. At the margins, what those limits should be will always be a matter of dispute. But if the kind of degradation described by Burris does not lie beyond the acceptable, nothing would.

But stigma need not always entail the brutal qualities adverted to by Burris. Indeed, he himself has referred to the "stigma of smoking" that has attended the adoption of increasingly restrictive measures that have reshaped the social milieu (Burris, 2006, p. 530). In fact, the broad conceptual framing proposed by Link and Phelan is mirrored in our ordinary language. Stigmatization commonly refers to a range of activities that provoke feelings of shame that create "spoiled identities." How should we think about the ethics of stigma construed in terms of segregation that is demeaning but not degrading? That is temporary rather than enduring? That entails the degrees of separation suggested by Link and Phelan? That involves a marginalization that can be shed? That permits, even has as its goal, the re-integration of those who have been shamed? Are public health measures that foster such stigmatizing processes morally acceptable?

In thinking about the extent to which those committed to public health can ever employ strategies that create social norms that involve elements of shaming and stigma, it would be useful to return to the case of the criminal law. Severe punishment for egregious acts may be justifiable for retributive or utilitarian reasons. But such punishments for minor infractions – even if they effectively contribute to deterrence – are not. A yardstick of proportionality, which is central to the human rights evaluation of measures that impose limits on the rights of individuals (Gostin, 2003), however imperfect must serve as a guide.

As we consider the moral status of stigma in public health campaigns, it will be critical to consider a number of empirical questions central to the instrumental and utilitarian underpinnings of public health policy: What is the pattern of morbidity and mortality that is the object of concern? Is it the consequence of other-regarding or self-regarding acts? What evidence is there that stigma may affect behaviors and hence reduce disease, suffering and death? What can be anticipated in terms of the severity, extent and duration of the suffering that the stigmatized will be compelled to bear? Only with answers to these questions will it be possible to make determinations that are morally compelling.

It will also be necessary to address the issue of equity: Who will bear the burden of stigma and are such burdens unfair? The discussion of stigma by human rights proponents and those whose worldview is framed by bioethics have routinely raised this question. But they have done so in a way that simply stipulates the inequity of the burdens involved. Stigma is almost always imposed by those with power or authority on those who are relatively powerless, but not necessarily defenseless. It is those inequalities that provide a foundation for the assault on stigmatization. Those who are already socially vulnerable are stigmatized and stigmatization adds to the burdens they bear.

But important as it is, this structural framing fails to address the central moral question of the ends to which power or the exercise of authority is deployed. Surely there is a difference between government programs that seek to mobilize social norms against those who subordinate women and give voice to homophobia and policies that reinforce such values. Surely there is a difference between the shaming of sexual behavior that is coercive and inflicts pain and the shaming of behavior that merely fails to conform to conventional standards of morality.

The case of tobacco is instructive in this regard. A marked social gradient has emerged in smoking behavior over the past several decades – the consequence of public health measures and broad normative shifts. People with more income and education are now far less likely to smoke than those at the lower end of the social stratification system in all economically advanced democratic societies (Feldman & Bayer, 2004, pp. 303–307). Hence, all restrictive and burdensome public health measures designed to further limit the prevalence of tobacco consumption are borne by those at the bottom of the social ladder. But the unequal burden of disease also raises questions of equity and efforts to lift that burden may justify the apparent inequity imposed by public health policy.

The use of consumption taxes for public health ends may provide a useful analogy. All such levies are by definition regressive since they fall most heavily on those with the most limited incomes. Thus, taxes on cigarettes, an increasingly significant aspect of the public health effort to reduce tobacco consumption, work precisely because they burden those least able to afford such levies. For those who do not begin to smoke, or those who give up smoking, such regressive burdens may present a life saving intervention. Those who continue to smoke, who cannot or will not give up cigarettes, bear the consequences of such interventions, compelled to endure a tax that serves the interest of others. It is precisely the prospect of so burdening consumption that has drawn the attention of proponents of new taxes on high fat fast foods.

The imposition of normative-sanctions, including those that are stigmatizing, should be thought of in the same way. They may be inequitable in the near term. But if they work, they may represent a significant contribution to the well-being of the very people they burden and on those who might be dissuaded from engaging in behaviors that have profound implications for health on a population level. What remains then is the troubling issue of those who cannot or will not change.

It is precisely because policy-induced stigma imposes burdens that those responsible for public health bear a special responsibility to provide case-appropriate assistance that may enhance the prospect of behavioral change. There are, of course, instrumental reasons for such interventions. Attempts to facilitate behavioral change may require such efforts. There are moral reasons as well. While it may be beyond their capacity to affect the social-structural factors that foster or sustain patterns of behavior that are inimical to health, public health bears a unique moral responsibility, an obligation, to offer interventions that may be necessary to aid those from whom change is expected. A robust and equitable paternalism requires nothing less.

This very preliminary analysis has sought to open a discussion of an issue that has for too long been encumbered by empirical preconceptions and unexamined moral assumptions. My purpose has not been to press the case for stigmatizing behaviors that may represent a public health threat to the community or to those who themselves are placed at risk because of their own behaviors. Rather, I have sought to demonstrate that there may be circumstances when public health efforts that unavoidably or even intentionally stigmatize are morally defensible. Whether it would be wise to do so in a particular case should be a matter of debate, one that should be framed by evidence and the utilitarian ethics that underpin the mission of public health.

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