THE FCTC AND THE PSYCHOLOGY OF TOBACCO CONTROL

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ABSTRACT

The Framework Convention on Tobacco Control (FCTC) is a promising public health accomplishment, but its emphasis on top-down, command-and-control approaches to tobacco control puts this promise at risk. The World Health Organization's "Guidelines for Implementation" of the FCTC prescribe restrictive regulation of artistic speech, contributions to popular culture, and even political speech, as well as constraints on promotion of tobacco products. This intrusiveness fails to take account much of what we know, from research in psychology and the neurosciences, about what prompts people to engage in risky behaviors and what empowers them to exercise restraint. The Guidelines (and the FCTC) start from the premise that people smoke either because they become "addicted" (rendering personal choice impossible) or because they fail to comprehend tobacco's dangers. But recent findings about the workings of the mind suggest a different story, a story of risky behavior (including smoking, unhealthy eating, and unsafe sex) as the product of competition between aspects of the self – between systems of perception and motivation that drive indulgence and restraint. We argue in this Essay that the WHO, in

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its "Guidelines", should pursue anti-smoking strategies that support individuals' self-restraint, rather than merely suppressing tobacco use in a coercive fashion. Alliances between governments and myriad actors that shape social and cultural norms and influence people's behavior, along with funding for research into the psychological determinants of tobacco use, will prove critical to this approach. Crude coercion, on the other hand, risks cultural backlash and even embrace of smoking as a way to express independence and rebellion.

KEYWORDS: *FCTC, Framework Convention on Tobacco Control, Guidelines for Implementation, tobacco, tobacco control, psychology, World Health Organization, WHO, World Health Assembly, WHA*

I. INTRODUCTION

There's a contradiction in the WHO's "Guidelines for Implementation" of the Framework Convention on Tobacco Control (FCTC) and the FCTC itself. The Guidelines begin with a declaration of war, announcing that "[t]here is a fundamental and irreconcilable conflict between the tobacco industry's interests and public health policy interests."[1] The FCTC and the Guidelines make the case for demanding the tobacco industry's unconditional surrender, setting forth a powerful critique of the tobacco industry's social uselessness and human destructiveness. The FCTC preamble sets the stage, recognizing the "need to be alert to any efforts by the tobacco industry to undermine or subvert tobacco control efforts and the need to be informed of activities of the tobacco industry that have a negative impact on tobacco control efforts."[2] Article 4 of the FCTC states that "[e]very person should be informed of the health consequences, addictive nature and mortal threat posed by tobacco consumption and exposure to tobacco smoke . . . ."[3] The Guidelines are relentless in their harsh portrayal of the tobacco industry, casting tobacco as the cause of disease, death, poverty, and other social ills.[4] Yet the FCTC and the Guidelines fail to follow through. They do not demand the industry's eradication, either immediately or as a long-term goal. They both presume and tolerate the tobacco industry's persistence – for the time being and over the long haul. Instead of seeking victory, they pursue a policy of containment.

This contradiction reflects political and psychological reality. Neither the tobacco industry nor the governments it influences are about to acquiesce to its eradication. The industry's political clout reflects more than its wealth and political connectedness. It has over a billion customers worldwide,[5] many of whom would fiercely resist a campaign of eradication and would seek ways to circumvent outright prohibition.

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[1] World Health Organization [hereinafter WHO], *Guidelines for Implementation of Article 5.3 of the WHO Framework Convention on Tobacco Control*, at 2, FCTC/COP3(7) (Nov. 17-22, 2008), *available at* http://www.who.int/fctc/guidelines/article_5_3.pdf (last visited Mar. 16, 2010) [hereinafter Article 5.3 Guidelines].

[2] WHO Framework Convention on Tobacco Control pmbl., May 21, 2003, 42 ILM 518, *available at* http://whqlibdoc.who.int/publications/2003/9241591013.pdf (last visited Mar. 16, 2010) [hereinafter FCTC].

[3] *Id*. art. 4.

[4] *See, e.g*., Article 5.3 Guidelines, *supra* note 1, ¶ 13 ("The tobacco industry produces and promotes a product that has been proven scientifically to be addictive, to cause disease and death and to give rise to a variety of social ills, including increased poverty."); *id.* ¶ 26 ("The tobacco industry conducts activities described as socially responsible to distance its image from the lethal nature of the product it produces and sells or to interfere with the setting or implementation of public health policies.").

[5] WHO, *Tobacco Facts*, http://www.who.int/tobacco/mpower/tobacco_facts/en/index.html (last visited Mar. 16, 2010).

But there is a psychological unrealism about the WHO's approach to containment in its Guidelines for Implementation of the FCTC. The Guidelines take a largely top-down approach to the challenge of reducing the risky behavior that over a billion people engage in. By calling for legislation to implement detailed packaging, labeling, and other requirements; by taking a heavy-handed approach to enforcement; and by pursuing forceful strategies for suppressing the industry's speech and public engagement, the Guidelines embrace aggressive, command-and-control methods. These methods overlook much of what we know about people's risk-taking behavior – and about what works to encourage risk-takers to exercise restraint. We argue in this Essay that the WHO's containment strategy, in its Guidelines, should be refocused to address the large influence of social cues and cultural norms on people's decisions to use tobacco – and on their will to resist. Rather than merely trying to compel the "right" choices, containment strategy should also strive to mobilize tobacco users' self-restraint, by attuning itself to the struggles that play out, within each of us, between temptation and the taking of the longer view that play out, within each of us. This is not to say that the law should play no part; to the contrary, the law can and should make a substantial contribution to control efforts by bolstering individual will to make "healthy" choices and to exercise self-restraint. But without realism about people's motives and the psychology of self-restraint, public backlash and industry attempts to undermine or circumvent tobacco control could impede anti-tobacco efforts.

We begin with some brief background on the legal import of the Guidelines as a basis for interpreting the obligations of State Parties to the FCTC. The Guidelines, we conclude, are not an authoritative construction of the Framework Convention, but they have interpretive significance as an indication of international anti-tobacco priorities. So they matter, and should be formulated with an eye to the psychological realities of tobacco use and control. The flexible language of the FCTC allows ample room for strategic reformulation of future Guidelines with this end in mind.

Next, we turn to the psychological premises concerning the causes of tobacco use that are embedded in the Guidelines' approach to implementing the Framework Convention. The Guidelines (and, to a lesser extent, the FCTC itself) build on the premise that people smoke because they become addicted or fall victim to failures of cognition – two concepts that are in tension with one another and that fail to capture comprehensively why people take the risks associated with tobacco use. The final part of this Essay begins to propose ways by which the Framework Convention and the Guidelines might more effectively build upon what we know about how competition between different aspects, or dimensions, of the "self" influences people's tobacco use. These ideas will require further unpacking

and development based on research and available resources. This Essay seeks to demonstrate that an expansive tobacco control approach that takes into account such struggle within the self has much potential to advance the goals of the FCTC.

II. BRIEF HISTORY OF THE FCTC AND THE GUIDELINES

A. The FCTC

Elements of a comprehensive international tobacco control program, in their nascent stages, were recommended to WHO member States in 1986 by the World Health Assembly (WHA). Included in these components was some recognition of the behavioral and other incentives that maintain and promote the use of tobacco.[6] The idea for a global tobacco control instrument was first circulated at the WHO in 1995,[7] followed in 1996 by the WHA's adoption of a resolution requesting that the WHO Director-General initiate the development of a framework convention on tobacco control.[8]

However, it was not until Dr. Gro Harlem Brundtland was elected Director-General in May 1998, with global tobacco control as her priority,[9] that the FCTC began to take life. In 1999, two bodies were formed to draft the convention, complete the negotiations, and submit the final text to the 56th WHA.[10] Not without obstacles,[11] these bodies completed their tasks,

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[6] World Health Assembly, *Tobacco or Health*, Resolution WHA39.14 (May 14, 1986), http://www.who.int/tobacco/framework/wha_eb/wha39_14/en/index.html (last visited Mar. 16, 2010). The WHA recommended the following tobacco control components: (1) measures to ensure that non-smokers receive protection from involuntary exposure to tobacco smoke; (2) measures to promote abstention from tobacco use so as to protect youth from becoming addicted; (3) measures to ensure that a good example is set in all health-related premises; (4) *measures leading to the progressive elimination of socioeconomic, behavioral, and other incentives which maintain and promote tobacco use*; (5) prominent health warnings on tobacco product containers; (6) the establishment of public education programs on tobacco/health issues; (7) monitoring of tobacco use trends, tobacco-related diseases, and effectiveness of national smoking control action; (8) the promotion of viable economic alternatives to tobacco production, trade and taxation; and (9) the establishment of a national focal point to stimulate, support, and coordinate the above. *Id.*

[7] *See* World Health Assembly, *An International Strategy for Tobacco Control*, Resolution WHA48.11 (May 12, 1995), http://www.who.int/tobacco/framework/wha_eb/wha48_11/en/index.html (last visited Mar. 16, 2010). *See generally* Ruth Roemer et al., *Origins of the WHO Framework Convention on Tobacco Control*, 95 AM. J. PUB. HEALTH 936, 936-38 (2005) (providing a succinct history of the FCTC from the perspective of scholars who played key roles in its origination).

[8] World Health Assembly, *International Framework Convention for Tobacco Control*, Resolution WHA49.17 (May 25, 1996), http://www.who.int/tobacco/framework/wha_eb/wha49_17/en/index.html (last visited Mar. 16, 2010).

[9] *See* Gro H. Brundtland, *Achieving Worldwide Tobacco Control*, 284 JAMA 750, 750-51 (2000).

[10] World Health Assembly, *Towards a WHO Framework Convention on Tobacco Control*, Resolution WHA52.18 (May 24, 1999), http://www.who.int/tobacco/framework/wha_eb/wha52_18/en/index.html (last visited Mar. 16, 2010). The two bodies included an intergovernmental

and, on May 21, 2003, the 56th WHA unanimously adopted the FCTC.[12] The FCTC was opened for signature on June 16, 2003 and went into force on February 27, 2005.[13]

In its brief life, the FCTC – which represents the first convention adopted by the WHO pursuant to its treaty-making authority[14] – has become one of the most widely embraced international treaties. The 167 States that have ratified or acceded to the treaty[15] represent more than 85% of the world's population.[16] The treaty is a 38-article, evidence-based instrument crafted with the goal of reducing the public health harms of the global tobacco epidemic. It also represents the first convention of its kind to target both the supply *and* demand of an addictive substance.[17] In these ways, the Framework Convention represents a remarkable accomplishment. Despite its international stature and its contemplation of global cooperation to curb tobacco use, however, the Convention's substantive provisions predominantly address matters of domestic legal governance.[18]

B. Guidelines

A governing body, the Conference of the Parties (COP), promotes and reviews the Framework Convention's implementation.[19] Comprised of all

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negotiating body, formed to draft and negotiate the proposed framework convention and possible related protocols, and a working group, tasked with preparing the work of the intergovernmental negotiating body. *Id.*

[11] *See* Gregory F. Jacob, *Without Reservation*, 5 CHI. J. INT'L L. 287, 290-301 (2004).

[12] World Health Assembly, *WHO Framework Convention on Tobacco Control*, Resolution WHO 56.1 (May 21, 2003), http://www.who.int/tobacco/framework/final_text/en/index1.html (last visited Mar. 16, 2010).

[13] WHO, *About the WHO Framework Convention on Tobacco Control*, http://www.who.int/fctc/about/en/ (last visited Mar. 16, 2010) [hereinafter About the FCTC]. Pursuant to Article 36, the FCTC shall enter into force 90 days after the 40th State has acceded to ratify, accept, or approve it. FCTC, *supra* note 2, art. 36.

[14] About the FCTC, *supra* note 13.

[15] For the purposes of this Essay, States which have ratified or acceded to the FCTC and are, therefore, bound by its provisions, will be referred to as State Parties. Because the FCTC prohibits Parties from making reservations pursuant to Article 30, State Parties are bound by all provisions of the FCTC without exception. FCTC, *supra* note 2, art. 30.

[16] Framework Convention Alliance, *Updated Status of the WHO FCTC: Ratification and Accession by Country*, Sept. 18, 2009, *available at* http://www.fctc.org/index.php?option=com_docman&task=cat_view&gid=131&Itemid=159 (last visited Mar. 16, 2010).

[17] FCTC, *supra* note 2, Foreword.

[18] A member of the United States delegation that negotiated the FCTC noted the following: "For an international treaty, the FCTC has remarkably little to do with international relations, and primarily covers matters pertaining to domestic law. Virtually every provision of the treaty could be enacted into law by willing countries even in the treaty's absence. Indeed, many countries, such as Canada, Australia, and the United States, had all but a few of the treaty's provisions in place before the negotiations began and went into the negotiations with the goal of bringing the rest of the world up to their standards." Jacob, *supra* note 11, at 287.

[19] The COP has the authority to take decisions necessary to promote the effective implementation of the FCTC and to adopt protocols, annexes, and amendments thereto. FCTC, *supra* note 2, art. 23.

State Parties to the FCTC, the COP holds biennial sessions and typically reaches decisions by consensus.[20] The COP has authority to issue guidelines for the implementation of non-price approaches to reducing tobacco consumption.[21]

Pursuant to this authority, the COP adopted guidelines for the implementation of Article 8 (Protection from exposure to tobacco smoke) in 2007. Guidelines for the implementation of Articles 5.3 (Protection of tobacco control policies from commercial and other vested interests),[22] 11 (Packaging and labeling of tobacco products), and 13 (Tobacco advertising, promotion and sponsorship) were also adopted in 2008.[23] In addition, the COP has charged four working groups with the task of drafting guidelines (for possible adoption in 2010) for six additional articles.[24] It is thus possible that by 2010, guidelines for the implementation of articles related to increasing public awareness of tobacco control issues (Article 12) and promoting cessation of tobacco use and treatment for tobacco dependence (Article 14) will be available.

The FCTC Secretariat, designated by the COP to support State Parties in fulfilling their duties under the Convention and to provide necessary support to the COP,[25] has characterized the Guidelines as a "valuable tool" that aims to "reflect and promote best practices and standards" intended to help State Parties meet their obligations under the Framework Convention.[26] The Guidelines take a narrative form, typically beginning with background discussion (including statements of purpose and principles), then making recommendations. Although the layout and tone of

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[20] About the FCTC, *supra* note 13; FCTC, *supra* note 2, art. 23, 28(3), 29(1), 33(2). If all efforts at consensus have been exhausted and no agreement reached, amendments and protocols may be adopted by a three-quarters majority vote of the Parties present and voting at the session as a last resort. *Id.* art. 28(3), 33(2).

[21] FCTC, *supra* note 2, art. 7 (Article 7 grants the COP authority to propose guidelines for the implementation of the provisions of Articles 8 to 13, which include all non-price measures to reduce the demand for tobacco.). In addition, Article 9 specifically requires the elaboration of guidelines for testing and measuring the contents and emissions of tobacco products, and for the regulation of such contents and emissions. *Id.* art. 9.

[22] Given that the COP is nowhere explicitly granted authority to issue guidelines pursuant to Article 5.3, it must be assumed that the State Parties (which comprise the COP) have done so pursuant to their plenary powers to adopt guidelines for implementation. *See* FCTC, *supra* note 2, art. 5.4.

[23] WHO, *Guidelines for the Implementation of the WHO Framework Convention on Tobacco Control* (2009), http://whqlibdoc.who.int/publications/2009/9789241598224_eng.pdf (last visited Mar. 16, 2010) [hereinafter Guidelines].

[24] WHO, *Working Groups Established by the Conference of the Parties*, http://www.who.int/fctc/cop/working_groups/en/index.html (last visited Mar. 16, 2010) These articles include Article 9 (Regulation of the contents of tobacco products), Article 10 (Regulation of tobacco product disclosures), Article 12 (Education, communication, training and public awareness), Article 14 (Demand reduction measures concerning tobacco dependence and cessation), and Articles 17 (Provision of support for economically viable alternative activities) and 18 (Protection of the environment and the health of persons). *Id.*

[25] FCTC, *supra* note 2, art. 24.

[26] Guidelines, *supra* note 23, Foreword.

the Guidelines differ one to another, they are intended to be accessible and informative to State Parties.

C. Legal Status of the FCTC and the Guidelines

In some ways, the FCTC is unusually specific – for a "framework" convention – concerning duties and deliverables.[27] For example, Article 11 obligates each State Party to adopt and implement, in accordance with national law, detailed tobacco packaging and labeling measures within three years after entry into force of the FCTC for that Party.[28] Within five years after entry into force, Article 13 requires the Party to undertake "appropriate" legislative, administrative, and other measures and to report to the COP concerning implementation of a comprehensive ban on all tobacco advertising, promotion, and sponsorship.[29]

In other ways, the FCTC represents a more traditional "framework" convention, designed to be strengthened and embellished by future steps – such as protocols, amendments, and annexes.[30] In this vein, the FCTC has been criticized for sometimes using non-obligatory words [31] or for insufficient clarity concerning State Parties' obligations. [32] Because the FCTC is at the same time (and often in the same articles) specific and general, State Parties are left to ponder its purpose and function as compared to future protocols or other FCTC-related instruments, such as

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[27] Chang-fa Lo, *Establishing Global Governance in the Implementation of FCTC: Some Reflections on the Current Two-Pillar and One Roof Framework*, 1 ASIAN J. WTO & INT'L HEALTH L. & POL'Y 569, 580-81 (2006); Jacob, *supra* note 11, at 290.

[28] FCTC, *supra* note 2, art. 11. For example, each Party must adopt and implement measures to ensure that "tobacco product packaging and labelling do not promote a tobacco product by any means that are false, misleading, deceptive or likely to create an erroneous impression about its characteristics, health effects, hazards or emissions, including any term, descriptor, trademark, figurative or any other sign that directly or indirectly creates the false impression that a particular tobacco product is less harmful than other tobacco products. These may include terms such as 'low tar', 'light', 'ultra-light', or 'mild'". *Id.* art. 11(1)(a).

[29] *Id.* art. 13(2).

[30] Lo, *supra* note 27, at 579-81; *see generally* WHO, *Framework Convention on Tobacco Control Technical Briefing Series: The Framework Convention/Protocol Approach*, at 11, WHO/NCD/TFI/99.1 (1999) (*prepared by* Daniel Bodansky) ("The framework convention/protocol approach allows law-making to proceed incrementally, beginning with a framework convention that establishes a general system of governance for an issue area, and then developing more specific commitments and institutional arrangements in protocols.")

[31] Lo, *supra* note 27, at 585 (referencing, for example, the language of Article 14, requiring Parties to "endeavor" to design and implement effective programs targeted at promoting the cessation of tobacco use in particular locations).

[32] *Id.* For example, paragraph 4 of Article 13 sets forth minimum tobacco advertising, promotion, and sponsorship requirements *in accordance with a Party's constitution or constitutional principles*, followed by encouragement in paragraph 5 that Parties adopt measures beyond these "obligations" set out in paragraph 4. FCTC, *supra* note 2, art. 13(4)-(5).

guidelines.[33]

In any event, the Framework Convention's provisions are legally binding on State Parties. What is less clear is the legal status of the Guidelines. The Secretariat for the FCTC took the following position when elaborating upon the guidelines for implementation of Articles 7 and 9:

> Guidelines constitute a non-binding instrument adopted by an international body to provide assistance to countries in addressing specific issues at the national or international level. This type of instrument is often used in the context of complex technical or legal matters. It is designed to provide a reference frame and detailed guidance to countries in adopting national measures on the issues in question. In the framework of international treaties, guidelines are often developed to assist parties in implementing treaty provisions on complex issues.[34]

Other guidance suggests that the Guidelines have greater legal significance.[35] For instance, the Vienna Convention on the Law of Treaties, which sets out widely-accepted treaty interpretation rules, states that "any subsequent agreement between the parties regarding interpretation of [a] treaty or the application of its provisions" shall be taken into account, together with the context, when interpreting a treaty.[36] Because the Guidelines are adopted unanimously by the COP (which is comprised of all State Parties), they arguably constitute a subsequent agreement and may, therefore, be taken into consideration when interpreting FCTC provisions.

A plain reading of the Guidelines in the context of the FCTC, however, suggests that many, if not all, are less than legal requirements. As mentioned above, the Guidelines often take the self-declared form of "recommendations". They also vary considerably among each other in format and style. Furthermore, they regularly employ such words as "should," "encourage," and "consider," rather than the "shall" used

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[33] *See* Jacob, *supra* note 11, at 299-300 (describing how the FCTC negotiation process resulted in a code for tobacco regulation that is probably too detailed to justify the negotiation of further protocols, but that leaves many important provisions "watered down" to accommodate the needs and domestic circumstances of negotiating countries).

[34] WHO, *Additional Matters Identified in the Convention for Consideration by the Conference of the Parties: Elaboration of Guidelines for Implementation of Article 7 and Article 9, and Elaboration of Protocols*, at 2, A/FCTC/COP/1/INF.DOC./3 (Jan. 5, 2006).

[35] *See generally* Sam F. Halabi, The World Health Organization's Framework Convention on Tobacco Control: An Analysis of Guidelines by the Conference of Parties 6-8 (Sept. 22, 2009) (unpublished manuscript on file with authors).

[36] United Nations Vienna Convention on the Law of Treaties art. 31, May 22, 1969, 1155 U.N.T.S. 331 (May 23, 1969), *available at* http://untreaty.un.org/ilc/texts/instruments/english/conventions/1_1_1969.pdf (last visited Mar. 16, 2010).

commonly in the FCTC. This would suggest that the Guidelines are advisory in nature, rather than mandatory.[37]

To take just a few examples, the Article 5.3 guidelines expressly acknowledge and respect State Parties' rights to formulate their own economic and tax policies. They recommend, rather than require, that State Parties respect their commitments to tobacco control by withholding preferential treatment (e.g., subsidies and tax exemption) from the tobacco industry.[38] These same guidelines also encourage, in a general fashion, the use of appropriate enforcement mechanisms to ensure guideline compliance.[39] The Article 11 guidelines condition certain packaging and labeling requirements on available resources and time, [40] implicitly deferring to State Parties to make judgments concerning availability. Further, the Article 13 guidelines are couched in discretionary terms, allowing State Parties to accommodate for constitutional constraints when implementing tobacco promotion and advertising bans.[41]

To be sure, aspects of the Guidelines can be read in more obligatory fashion – in particular, the Article 8 guidelines.[42] When taken together with the Secretariat's comments regarding the purpose of these Guidelines, however, it is difficult to argue that they now constitute legally binding instruments. Whether they will become customary international law based upon consistent State conduct over time,[43] whether they already constitute international "soft law,"[44] and whether they are legally enforceable in national jurisdictions,[45] are broader topics beyond the scope of this Essay. Suffice it to say, for current purposes, that the Guidelines elaborate upon

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[37] Halabi, *supra* note 35, at 8.

[38] "Without prejudice to their sovereign right to determine and establish their economic, financial and taxation policies, Parties should respect their commitments for tobacco control." Article 5.3 Guidelines, *supra* note 1, ¶ 29.

[39] "Parties *should be encouraged* to use and enforce mechanisms to ensure compliance with these guidelines, such as the possibility of bringing an action to court, and to use complaint procedures such as an ombudsman system." *Id.* ¶ 34 (emphasis added).

[40] "*Depending on the available resources and time*, Parties *should consider* pre-marketing testing to assess the effectiveness of the health warnings and messages on the intended target population." WHO, *Guidelines for Implementation of Article 11 of the WHO Framework Convention on Tobacco Control*, ¶ 39, FCTC/COP3(10) (2008), http://www.who.int/fctc/guidelines/article_11.pdf (last visited Mar. 16, 2010) (emphasis added) [hereinafter Article 11 Guidelines].

[41] *See* WHO, *Guidelines for Implementation of Article 13 of the WHO Framework Convention on Tobacco Control*, ¶¶ 35-36, FCTC/COP3(12) (2008), http://www.who.int/fctc/guidelines/article_13/en/index.html (last visited Mar. 16, 2010) [hereinafter Article 13 Guidelines].

[42] Halabi, *supra* note 35, at 10-13. *See, e.g.*, WHO, *Guidelines on Protection from Exposure to Tobacco Smoke*, ¶¶ 2-3, 6-8, 24, FCTC/COP2(7) (2007), http://www.who.int/fctc/guidelines/article_8/en/index.html (last visited Mar. 16, 2010) [hereinafter Article 8 Guidelines] (identifying the elements of legislation necessary to protect people from tobacco smoke).

[43] *See* SHABTAI ROSENNE, PRACTICE AND METHODS OF INTERNATIONAL LAW 55 (1984).

[44] *See generally* Jacob E. Gersen & Richard A. Posner, *Soft Law: Lessons from Congressional Practice*, 61 STAN. L. REV. 573, 624-25 (2008) (arguing that international soft law can anticipate hard law and can change behavior by supplying information about lawmaker goals).

[45] Halabi, *supra* note 35, at 30-34.

the State Parties' intentions and goals in implementing the FCTC and that they offer insight into the tobacco control strategy advanced by the FCTC governance process. To the extent that the Guidelines are reflected in the reporting instrument of the Framework Convention adopted by the COP,[46] they also become a benchmark for judging State Party compliance.

III. CAUSES OF TOBACCO USE

Implicit (and at times explicit) in the FCTC and, even more so, the Guidelines are two accounts of the causes of tobacco use: addiction and failed cognition. These accounts are in tension with each other, although nowhere is this contradiction acknowledged in the language of the Convention or the Guidelines. These accounts, furthermore, fail to capture exhaustively why people take the risk of using tobacco. What are the FCTC and (to a greater degree) the Guidelines missing in their understandings of why people use tobacco and what causes people to stop? We submit that the WHO's instruments misapprehend the psychology that drives tobacco use and that, at times, motivates self-restraint – the inner struggles that people face between different aspects and dimensions of themselves.

A. Addiction & Cognitive Failure

The FCTC and the Guidelines cast tobacco as "addictive," building on evidence that people who smoke are neurobiologically driven to inhale more nicotine.[47] The FCTC sets out the principles that "everyone should be informed of the health consequences, addictive nature, and mortal threat posed by tobacco."[48] The Article 5.3 guidelines say the following about addiction: "The tobacco industry produces and promotes a product that has been proven scientifically to be *addictive*, to cause disease and death and to give rise to a variety of social ills, including increased poverty." [49] (emphasis added) The Article 5.3 guidelines also recommend that State Parties: "[r]aise awareness about the *addictive* and harmful nature of tobacco products and about tobacco industry interference with Parties'

[46] *See* Article 5.3 Guidelines, *supra* note 1, ¶ 38 ("[T]he Convention Secretariat should ensure that the principal provisions of these guidelines are reflected in the next phases of the reporting instrument, which the Conference of the Parties will gradually adopt for use by Parties.")

[47] *See* Frank J. Chaloupka et al., *The Economics of Addiction*, *in* TOBACCO CONTROL IN DEVELOPING COUNTRIES 107, 109-10 (Prabhat Jha & Frank J. Chaloupka eds., 2000).

[48] FCTC, *supra* note 2, art. 4.1. Parties also are generally obliged, in accordance with their capabilities, to "adopt and implement effective legislative, executive, administrative and/or other measures and cooperate, as appropriate, with other Parties in developing appropriate policies for preventing and reducing tobacco consumption, nicotine addiction and exposure to tobacco smoke." *Id.* art.5.2. (b).

[49] Article 5.3 Guidelines, *supra* note 1, ¶ 13.

tobacco control policies."[50] (emphasis added) Moreover, the Article 11 guidelines assert the following: "Health warnings and messages should address different issues related to tobacco use, in addition to harmful health effects and the impact of exposure to tobacco smoke, such as … the *addictive* nature of tobacco".[51] (emphasis added)

There is, of course, medical consensus regarding the addictive qualities of nicotine, a chemical found in tobacco products.[52] Because tobacco companies exploit the addictive nature of their products, the WHO holds, the industry should be held accountable for individuals' smoking habits and other tobacco use. Implicitly, this account treats smokers as blameless – as victims of a deterministic, biological process that they cannot control.

The FCTC and the Guidelines prioritize smoking prevention to avoid addiction over breaking the chain of addiction. The FCTC itself gives short shrift to those individuals who are already addicted to nicotine by failing to place firm mandates on State Parties to offer smoking cessation programs. Although Article 14 covers demand reduction measures concerning tobacco dependence and cessation,[53] it has been criticized as lacking self-executing requirements by nature of its "hortatory rather than legal statements," and "soft rather than hard law."[54] Guidelines for Article 14 may be available in 2010, but this guidance has not yet been a COP priority and its future status remains unclear.

The Guidelines also embrace the idea that people smoke or otherwise use tobacco because their reasoning fails them. "Globally, many people are not fully aware of, misunderstand or underestimate the risks for morbidity and premature mortality due to tobacco use and exposure to tobacco smoke," the Article 11 guidelines state.[55] People will stop smoking, or smoke less, or, preferably, never start if they reason appropriately, based on sound information. In order to remedy this cognitive failure, the WHO instruments hold, better education is required – through package labeling, awareness campaigns, truthful advertising, and other programs that provide

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[50] *Id*. ¶ 17(1).
[51] Article 11 Guidelines, *supra* note 40, ¶ 23.
[52] *See supra* note 47 and accompanying text.
[53] Article 14 is devoted to demand reduction measures concerning tobacco dependence and cessation: it requires each Party to develop and disseminate comprehensive guidelines based on scientific evidence and best practices and to take effective measures to promote smoking cessation and treatment for tobacco dependence. FCTC, *supra* note 2, art. 14.
[54] Benjamin M. Meier, *Breathing Life into the Framework Convention on Tobacco Control: Smoking Cessation and the Right to Health*, 5 YALE J. HEALTH POL'Y, L. & ETHICS 137, 149 (2005).
[55] Article 11 Guidelines, *supra* note 40, ¶ 3. *See* Donald Kenkel & Likwang Chen, *Consumer Information and Tobacco Use*, *in* TOBACCO CONTROL IN DEVELOPING COUNTRIES 177, 181-96 (Prabhat Jha & Frank J. Chaloupka eds., 2000) for a discussion and literature review of consumer knowledge about the risks associated with tobacco use. The authors conclude that many people do not fully realize the health consequences of tobacco use and that teens (including in the United States) underestimate the risk of becoming addicted to smoking. *Id.*

additional, accurate information to consumers.[56]

These two accounts of causation are somewhat at odds with each other, although nowhere in the FCTC or Guidelines is this contradiction acknowledged. If tobacco use is biologically determined by nicotine exposure, then cognition is irrelevant – except insofar as education might deter people from smoking in the first instance. This, again, is the story of the helpless addict who lacks control over his or her actions. If, on the other hand, lack of knowledge and failures of reasoning cause people to use tobacco, then tobacco control programs should aim to inform people and improve their reasoning. The WHO should insist that tobacco companies not mislead consumers, and it should insist on better health warnings – as it does in both the FCTC and Guidelines. This causal account casts tobacco users as active agents, in control of their own smoking destinies (if given the necessary information), not as passive victims of brain biology. It thus treats well-informed individuals as responsible for their behaviors, contrary to the addiction paradigm.

The plausibility of the WHO's contradictory causal accounts deserves further investigation. The addiction account falls short of telling the whole story behind smoking (or other tobacco use). Although nicotine makes tobacco attractive to many, some people try smoking, but don't develop the habit; others smoke occasionally or socially; and still others quit altogether. More is at play than biological determinism, switched on by nicotine exposure.

The addiction account rests on submerged political premises. The addiction story invokes brain chemistry: nicotine, the story holds, triggers neurochemical processes that reward smoking behavior and engender cravings when a smoker is between cigarettes.[57] But the same can be said of engaging in risky sex, overeating, or consumption of sugary foods.[58] All behaviors are biologically caused, yet we are not prepared to treat them all (for public policy purposes) as biologically determined. "Addiction" is a

[56] Additional guidelines may be available as early as 2010 for Article 12 relating to education, communication, training, and public awareness. *See supra* note 24. Such guidelines would further expand upon the State Parties' understanding of the FCTC obligations with respect to Article 12. *See* Kenkel & Chen, *supra* note 55, at 205-09, for evidence-based support for the efficacy of mass-media counter-advertising campaigns and warning labels in tobacco control efforts.

[57] Addictive consumption is sometimes distinguished from other kinds of consumption by the presence of three factors: tolerance, reinforcement, and withdrawal. Other definitions emphasize compulsive consumption, intoxication, and impairment of control. *See* Chaloupka et al., *supra* note 47, at 110.

[58] For instance, a Princeton study examining the neurochemical similarities between the effects of intermittent sugar access and drugs of abuse such as nicotine suggests that sugar meets the criteria for a substance of abuse and may be "addictive" for some individuals when consumed in a "binge-like" fashion. The conclusion is reinforced by the changes in limbic system neurochemistry that are similar for the drugs and for sugar. Nicole M. Avena et al., *Evidence for Sugar Addiction: Behavioral and Neurochemical Effects of Intermittent, Excessive Sugar Intake*, 32 NEUROSCIENCE & BIOBEHAVIORAL REV. 20 (2008).

label we as a society use to signify a political and moral judgment about responsibility and accountability. We invoke this notion when we wish to make a statement that the behavior is outside the bounds of personal responsibility. We also use the label to make policy judgments about which actors to target in order to treat a problem. In the case of tobacco, treating nicotine as "addictive" suggests that the tobacco industry is to blame and that the individual is absolved of moral responsibility. We do not, in general, employ the same notion of "addiction" to describe consumption of candy bars; rather, we treat people as responsible for controlling their candy bar consumption. We don't blame the candy bar maker for exploiting human vulnerability.

The flawed cognition theory – the proposition that people smoke because they don't know, or underestimate, the risks, does capture some of what is going on.[59] Certain less-educated persons, especially in less-developed countries, lack basic information about the dangers of smoking.[60] But many people smoke *despite* knowing the risks. Some of these people express a desire to quit – and some may quit for a time, only to start smoking again at a later point. Providing these people with more detailed, statistical data concerning the risks is unlikely to change their behavior.[61]

So why do these people who fully understand the associated risks still smoke? Some, perhaps, place less importance on the health consequences of smoking – and greater value on its pleasures – than is warranted from the perspective of tobacco control advocates. Advocates aim either to change this calculus (by encouraging smokers to place higher values on health consequences) or to impose their risk-benefit balancing judgments upon users. There are legitimate reasons for doing both: paternalism here can be justified, especially for children and young adults, and the negative externalities of tobacco use (including lost productivity, medical costs, and family suffering after premature death) are classic grounds for public intervention. But something more than cognitive failure is involved in making the case for public intervention. There is a moral dimension to this case: tobacco control advocates take the position that smokers neglect their

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[59] In Russia, for instance, which has been targeted by the transnational tobacco industry since the political transition in 1991, people's knowledge of the impact of smoking on health was limited, and people severely underestimated the dangers and addictive qualities of tobacco. The authors recommend improved antismoking education campaigns to counter this misinformation. Kirill Danishevski et al., *Public Attitudes Towards Smoking and Tobacco Control Policy in Russia*, 17 TOBACCO CONTROL 276, 281-82 (2008).

[60] *See* Kenkel & Chen, *supra* note 55, at 182-87.

[61] *See id*. at 209-10 (emphasizing the need in countries such as the United States, where understanding of the health risks and consequences of tobacco use is sophisticated, to adopt new approaches (other than simply imparting information) to incentivize smokers to quit. Researchers also suggest highlighting the personal risk associated with smoking, rather than just the general risk, in consumer information campaigns).

obligations to their loved ones, to society as a whole, and to their longer-term selves.

What of the many people who want to quit (or say they do), but do not? Why do they fail? Tobacco control advocates point to "addiction," but this explanation is circular. "Addiction" is a term we invoke to convey the *moral* judgment that neurobiological causation absolves an individual from responsibility for his or her substance use. All habitual behaviors can, in theory, be explained in neurobiological terms. Calling only some of these behaviors "addictive" constitutes normative judgment, not causal explanation.

Thus the question remains: what causes tobacco use that people say they would rather not engage in? A corollary question, more critical from a public health perspective, is what can cause, or inspire, people drawn to smoking (or to overeating, risky sex, or other hazardous activities without a payoff that society deems worthwhile) to exercise restraint?

B. Inner-Struggles

What we do know from a broad range of work in the neurosciences and psychology is this: what individuals experience as "self" is a composite of interacting structures of perception and motivation. It is this complex "self" that makes decisions – decisions driven by intermingled brain circuits that struggle for control – and that can be tracked by brain scanning technologies. Associated with different patterns of brain activation are different, subjectively-experienced states of mind – states of mind marked by mixes of feeling and belief.

Neurobiological researchers have employed brain scanning technologies, such as Positron Emission Tomography (PET) and functional Magnetic Resonance Imaging (fMRI) scanning, to identify areas of increased activation in experimental subjects' brains when they make decisions.[62] This research has found associations between patterns of brain activation and subjects' preferences and judgments.[63] Different decisions correlate with different distributions of increased activation. Variations in the activity levels of different brain systems appear to underlie (and drive) people's differing choices.

Psychodynamic and cognitive psychologists have also developed

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[62] Specifically, these technologies can detect changes in the intensity of brain tissue activity based on localized changes in blood flow or glucose.

[63] *See* M. Gregg Bloche, *Obesity and the Struggle within Ourselves*, 93 GEO. L.J. 1335, 1348 (2005) (citing, Markus Ullsperger & D. Yves von Cromon, *Decision Making, Performance and Outcome Monitoring in Frontal Cortical Areas*, 7 NATURE NEUROSCIENCE 1173 (2004); K. Richard Ridderinkhof et al., *The Role of the Medial Frontal Cortex in Cognitive Control*, 306 SCIENCE 443 (2004); Mark E. Walton et al., *Interactions Between Decision Making and Performance Monitoring Within Prefrontal Cortex*, 7 NATURE NEUROSCIENCE 1259 (2004)).

models of decision-making that explain peoples' choices as products of competition between states of mind.[64] The notion of rival "selves" has been invoked by some to convey the idea of different mental systems of understanding and motivation, systems that shape the stories we tell ourselves about the situations we encounter. The stories that "win" out in particular cases drive our decisions and actions, psychodynamic theorists assert. This process is often unconscious[65] rendering people's component "selves" difficult to discern. Cognitive psychology theories similarly focus on individuals' patterns of perception, discerning heuristics, often unconscious, that influence judgment. The patterns can be inherited or acquired, and they are much-influenced by our fears,[66] desires, and needs.[67] These models, moreover, are consistent with behavioral economics research establishing that decisions vary greatly with perceived context.[68]

The mental systems of perception and motivation that comprise the composite "self" sometimes reinforce each other but often conflict. The sellers of sundry consumer products have become expert at exploiting people's inner conflicts. One need merely stand at a supermarket checkout counter to see that many magazine editors have preternatural understandings of people's struggles over desire and self-restraint. Delicious pastries, diet plans, sexual adventure, and much more beckon from the magazine racks. Editors and product-sellers alike ally themselves with both individual cravings and the will to resist temptation.

Different mental systems, or states of mind, vie for command, or strike compromises with each other, for a broad range of human temptations. Fear, social status, shame, sexual feelings, and many other motivations get varying weights as people shift among these states of mind. How individuals respond to temptation when cigarette smoking or candy-bar eating opportunities present themselves is a product of the state of perception and motivation of the individual at a given time. For example, a person wearing a skimpy swimsuit at the beach might forego the same candy bar that he or she would readily eat if dressed in baggy sweats at home. Recent research documenting close correlations between obesity and participation in social networks with other overweight people underscores

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[64] For this reason, psychodynamic and cognitive psychology theories better explain people's contradictory intentions as regards smoking and eating than does the welfare economics story of hyperbolic discounting. *See id*. at 1343-48.

[65] *See id*. at 1346 (citing ROY SCHAFER, THE ANALYTIC ATTITUDE (1983)).

[66] *See id*. at 1347 (citing George Loewenstein et al., *Risk as Feelings*, 127 PSYCHOL. BULL. 267, 267 (2001)).

[67] *See id*. (citing George Loewenstein, *Out of Control: Visceral Influences on Behavior*, in ADVANCES IN BEHAVIORAL ECONOMICS 689-723 (C.F. Cemerer, G. Loewenstein, & M. Rabins eds., 2004)).

[68] For example, people's decisions are impacted by how options are framed. *See id*. (citing Amos Tversky & Daniel Kahneman, *The Framing of Decisions and the Psychology of Choice*, 211 SCIENCE 453 (1981)).

the importance of social context and norms.[69] The challenge for public health intervention programs is to ally with states of mind, or mental systems of perception and motivation, that eschew risky indulgences in favor of healthier endeavors.

IV. A NEW TOBACCO CONTROL STRATEGY

The story of the "self" as a composite of oft-contradictory structures of perception and motivation has profound implications for tobacco control. What tobacco companies do so well when they craft advertisements and other promotions is to evoke those states of perception and motivation most likely to encourage smoking.[70] When viewed in this light, the FCTC and, to a greater degree, the Guideline provisions concerning health warnings, package labeling, industry promotional efforts, and other influences on demand are inadequately targeted.[71] The guidance is overly focused on cognitive failure, relying on the notion that people can reason better with increased information. It is inattentive to tobacco users' inner struggles. It thus takes insufficient account of what prompts people to use tobacco and what empowers them to exercise restraint.

A. Social Cues and Cultural Norms

Understanding the inner struggles that influence tobacco use is critical to discouraging it. Doing so must be the work of individuals, not just governments. People, with the help of family, friends, and treatment specialists, should endeavor to identify the environmental influences that lead to smoking or other uses of tobacco. Particular stressors and temptations, social cues, and surrounding cultural norms are among the

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[69] Nicholas A. Christakis & James H. Fowler, *The Spread of Obesity in a Large Social Network Over 32 Years*, 357 NEW ENG. J. MED. 370, 375-78 (2007).

[70] *See, e.g.*, Jennifer Knight & Simon Chapman, *"Asian Yuppies…are Always Looking for Something New and Different": Creating a Tobacco Culture Among Young Asians*, 13 TOBACCO CONTROL ii22, ii22-ii27 (2004) (discussing how the tobacco industry created a culture in which smoking became desirable and normalized for young Asian men and women using six vehicles: music, entertainment, adventure, glamour, and independence); Pamela M. Ling & Stanton A. Glantz, *Why and How the Tobacco Industry Sells Cigarettes to Young Adults: Evidence from Industry Documents*, 92 AM. J. PUB. HEALTH 908, 908-13 (2002) (analyzing internal tobacco industry documents to find that tobacco companies study young adults' attitudes, social groups, values, aspirations, role models, and activities to inform marketing to young adults in their physical and social environments) [hereinafter Ling & Glantz I].

[71] Laws regulating these areas can be considered to change the "informational environment" when following the four meta-approaches developed by public health researchers to categorize legislative interventions to tobacco control. The other three include modifying the economic environment, altering the social environment and reducing the health impact. *See* James G. Hodge Jr. & Gabriel B. Eber, *Tobacco Control Legislation: Tools for Public Health Improvement*, 32 J.L. MED. & ETHICS 516, 516-19 (2004).

influences that can both inspire and suppress tobacco use. The crafting of interventions at the individual level is the province of clinicians, and it is beyond our scope here. But we note that clinical interventions are most likely to be effective when they forge alliances with components of the "self" that support restraint in the face of tobacco's temptations. Identifying patterns of thinking and feeling that support (and discourage) a person's tobacco use, then crafting strategies for dampening (or promoting) these patterns is the central challenge for clinicians who work in this field.

Individual willpower and discipline, however, will only take most people so far, particularly in light of the strong social cues and cultural norms that encourage tobacco use in many societies. Tobacco marketing efforts have been ingenious at creating smoking-oriented cultures all over the world where they previously did not exist. Strong anti-tobacco efforts in the United States have in recent years rendered smoking "uncool" and even socially reproachable in many circles,[72] but the industry has gone abroad to target women and young people, especially in developing countries.[73] Tobacco industry researchers scrutinize people's psychology, attitudes, physical environments, and activities, with an eye toward promotional possibilities.[74] Industry marketers employ this research to divide potential consumers into market segments, based on characteristics and needs that might make them susceptible to different promotional and sales approaches.[75]

Social science and public health research[76] can take us a long way

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[72] *See id*. at 518-19; Eric A. Feldman, *The Culture of Legal Change: A Case Study of Tobacco Control in Twenty-First Century Japan*, 27 MICH. J. INT'L LAW 743, 769-74 (2006).

[73] Knight & Chapman, *supra* note 70, at ii23-ii27 (analyzing, based on internal tobacco industry documents, tactics employed to market tobacco to women and youth in Asia. Strategies employed included, without limitation, sponsoring fashion designer shows, soccer cups, tennis tournaments, and theme nights at nightclubs. Tobacco industry also linked cigarettes to American culture in making it fashionable and cool.) *See also* National Cancer Institute, *Influence of Tobacco Marketing on Smoking Behavior*, in THE ROLES OF THE MEDIA IN PROMOTING AND REDUCING TOBACCO USE 211-91 (Ronald M. Davis et al. eds., 2008) (concluding, based on a literature review, that tobacco promotions increase consumption among tobacco users and encourage smoking among non-users).

[74] Pamela M. Ling & Stanton A. Glantz, *Using Tobacco-Industry Marketing Research to Design More Effective Tobacco Campaigns*, 287 JAMA 2983, 2983 (2002) [hereinafter Ling & Glantz II].

[75] *Id*. at 2983; Ling & Glantz I, *supra* note 70, at 908-13 (Researchers searched tobacco industry document archives using detailed search terms to identify documents whereby young adult smokers were surveyed about their concerns, beliefs, norms, values, leisure activities, and socialization patterns. The results of these surveys were used to identify common behavioral groups and the major motivators behind smoking activities.).

[76] With respect to youth marketing research, *see*, *e.g*., Erin L. Sutfin et al., *Adolescents' Responses to Anti-Tobacco Advertising: Exploring the Role of Adolescents' Smoking Status and Advertisement Theme*, 13 J. HEALTH COMM. 480, 495-96 (2008) (showing that adolescents respond to anti-tobacco advertisements focusing on negative life circumstances, rather than endangering others or industry manipulation, more favorably); Cornelia Pechmann & Ellen T. Reibling, *Antismoking Advertisements for Youths: An Independent Evaluation of Health, Counter-Industry, and Industry Approaches*, 96 AM. J. PUB. HEALTH 906, 906-11 (2006) (finding that it is

toward answering the questions of why people smoke and what causes people to exercise restraint. Anti-tobacco efforts designed to eliminate social triggers for tobacco use[77] can piggy-back on tobacco marketing studies[78] by building on what is known about consumers' needs and desires, not just their demographics.[79] These efforts should address the psychological needs of not just current and potential smokers, but all who are in a position to affect the shaping of social norms regarding tobacco use.[80] Finally, these efforts require coordinated action at national and international levels, given the global nature of both cultural norms and tobacco marketing campaigns.[81]

Simply put, anti-tobacco advocacy needs to form alliances with "cool" to drive changes in social norms and to take tobacco out of play as a marker of social status. Anti-tobacco campaigns should include sophisticated advocacy that builds on what is currently "cool" within the populations these campaigns aim to reach and that partners with admired institutions and public personalities – mimicking the sponsorship campaigns of the tobacco industry. These efforts have the greatest potential to activate patterns of perception and motivation hostile to tobacco consumption. The FCTC and the Guidelines do too little to encourage these strategies – or to provide the least well-off, most vulnerable State Parties with the means necessary to pursue them. The WHO instruments do not do enough to

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challenging to create effective antismoking advertisements for adolescents, and that the one type of advertisement that significantly lowered most youths' intent to smoke focused on young victims suffering from devastating tobacco-related illnesses); Matthew C. Farrelly et al., *Evidence of a Dose-Response Relationship Between "truth" Antismoking Ads and Youth Smoking Prevalence*, 95 AM. J. PUB. HEALTH 425 (2005) (using multivariable analyses that controlled for confounders, to show a statistically significant dose-response relationship between exposure to the American Legacy Foundation's national "truth" advertising campaign and current youth smoking prevalence during the first two years of the campaign). *See also* Matthew C. Farrelly et al., *The Influence of the National truth® Campaign on Smoking Initiation*, 36 AM. J. PREVENTIVE MED. 379 (2009); Pamela A. Ling et al., *The Effect of Support for Action Against the Tobacco Industry on Smoking Among Young Adults*, 97 AM. J. PUB. HEALTH 1449 (2007).

[77] Changing the social environment is a component of the public health systems approach used to counteract disease. The model addresses agent, host, vector, and environment. In the case of tobacco control, the FCTC and the Guidelines already reflect aspects of the agent (reducing availability of tobacco), host (decreasing the demand for tobacco), and vector (reducing the ability of the tobacco industry to create new tobacco addicts), but largely fails to address the environment ("fostering social norms whereby tobacco simply does not fit"). Scott J. Leischow, *Setting the National Tobacco Control Agenda*, 301 JAMA 1058, 1058 (2009). *See also* Hodge & Eber, *supra* note 71, at 518-19.

[78] "Gaining an understanding of the way the industry constructed a culture receptive to smoking provides insights into ways that same culture might be dismantled by tobacco control groups." Knight & Chapman, *supra* note 70, at ii26. *See generally* Ling & Glantz II, *supra* note 74.

[79] Ling & Glantz II, *supra* note 74, at 2983-87 (proposing that anti-tobacco campaigns focus on defining target markets by using consumer desires and needs rather than the typical public health approach of designing tobacco control programs based on demographics or constituencies).

[80] *Id*. at 2987-88.

[81] Knight & Chapman, *supra* note 70, at ii26. *See also* Feldman, *supra* note 72, at 748-49 (noting that the denormalization of smoking in the United States has been tracked in Japan).

oblige or encourage State Parties to pursue such advocacy strategies, nor do they provide the resources with which to do so.[82]

B. A New Conception of Public Policy and the Law

These tobacco control strategies aligned with social cues and cultural norms call for the WHO and the Framework Convention's State Parties to pursue a bottom-up approach, not just a top-down, command-and-control agenda. This means forging alliances with the panoply of actors that shape social norms, send cultural cues, and influence people's behavior at the ground-level. The makers and marketers of popular products, entertainment companies and professional sports leagues, and religious and civic organizations are among the crucial partners. Regrettably, the FCTC and the Guidelines thus far have little to offer on this front. Instead, they emphasize command-and-control approaches to restraining the tobacco industry's promotional efforts.

To be sure, command-and-control regulation of the sort called for in the Convention and, even more so, in the Guidelines serves important purposes and can even help to change social norms and cultural cues. Rotating warnings on packages is a promising idea,[83] to keep tobacco buyers alert and intrigued by warnings and to thereby encourage attentiveness to tobacco's risks. The warnings urged in the Guidelines emphasize fear as a motivator – as something that both package labeling and counter-advertising should aim to inspire.[84] This fear strategy should not be taken too far. Too much raw fear can cause people to disregard a message or even to hold the messenger in contempt.[85] Comprehensive tobacco advertising bans are effective ways to reduce exposure to the

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[82] The Convention and Guidelines confine themselves to hortatory, aspirational statements along these lines. *See*, *e.g.*, FCTC, *supra* note 2, art. 20(1), 22, 26; Article 13 Guidelines, *supra* note 41, ¶¶ 72-74.

[83] *See* Article 11 Guidelines, *supra* note 40, ¶¶ 19-22.

[84] *Id.* ¶ 26 ("Evidence suggests that health warnings and messages are likely to be more effective if they elicit unfavourable emotional associations with tobacco use and when the information is personalized to make the health warnings and messages more believable and personally relevant. Health warnings and messages that generate negative emotions such as fear can be effective, particularly when combined with information designed to increase motivation and confidence in tobacco users in their ability to quit.").

[85] *See* Gerard B. Hastings & Lynn MacFayden, *The Limitations of Fear Messages*, 11 TOBACCO CONTROL 73, 73-75 (2002) (arguing that fear messages, though important in the sense that they inform people of the dangers of smoking, are of questionable value when repeated to a population that knows the dangers of smoking). *See also* Pechmann & Reibling, *supra* note 76, at 906 (asserting that evoking fear of tobacco may have two major limitations: (1) this strategy may lead to maladaptive responses, such as denial of the problem, among adolescents who feel unable to cope, and (2) it may serve to increase the attractiveness of smoking as the "forbidden fruit" among adolescents who feel invincible. Instead of fear, the authors advocate evoking disgust.).

industry's marketing influences,[86] and bans on smoking in public settings can tilt social norms against tobacco use.[87]

But the WHO may overreach when it embraces command-and-control approaches to artistic speech in the Guidelines. For example the Article 13 guidelines require that anti-smoking advertisements approved by governments appear at the start of films or other creative works that depict tobacco use.[88] They also recommend that State Parties implement a ratings or classification system that (1) takes into account the depiction of tobacco products, use, or images in rating or classifying entertainment media products and (2) ensures media aimed at children not depict tobacco products, use, or image.[89] The justification for these ratings is to shield youth from portrayals of smoking as glamorous or acceptable.[90] What may be underestimated, however, is the allure of the forbidden.

The above restrictions unduly constrain both the content of speech and its means of dissemination. Free societies need to strike balances between liberty and health. These restrictions, moreover, have the potential to invite backlash – to encourage people to see public health regulators as censors. And it is hardly obvious that portrayal of smoking in the media and the arts will be favorable, absent regulation. In many countries, including the United States, smoking has become an embarrassing habit, likely to be portrayed negatively in popular media. For example, Grace Augustine's smoking in the recent blockbuster "Avatar" is meant to portray her less attractive personality characteristics, according to the film's director, James Cameron.[91] Along the same lines, the principal smoker in the recent

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[86] *See, e.g.*, Henry Saffer, *Tobacco Advertising and Promotion*, in TOBACCO CONTROL IN DEVELOPING COUNTRIES 215, 215-36 (Prabhat Jha & Frank J. Chaloupka eds., 2000); Fiona Harris et al., *Effects of the 2003 Advertising/Promotion Ban in the United Kingdom on Awareness of Tobacco Marketing: Findings from the International Tobacco Control (ITC) Four Country Survey*, 15 TOBACCO CONTROL iii26, iii26-iii33 (2006); Hodge & Eber, *supra* note 71, at 518; Ronald Bayer et al., *Tobacco Advertising in the United States: A Proposal for a Constitutionally Acceptable Form of Regulation*, 287 JAMA 2990, 2993 (2002). *See also* Diane M. Straub et al., *Effects of Pro- and Anti-Tobacco Advertising on Nonsmoking Adolescents' Intentions to Smoke*, 32 J. ADOLESC. HEALTH 36, 36-42 (2003) (finding that although anti-tobacco advertising has a protective effect, it was insufficient to counteract the effects of pro-tobacco advertising in the same population).

[87] Hodge & Eber, *supra* note 71, at 518-19. *See generally* Article 8 Guidelines, *supra* note 42.

[88] Article 13 Guidelines, *supra* note 41, ¶ 31.

[89] *Id.*

[90] *Id.* In the United States, the Motion Picture Association of America (MPAA) has considered smoking when rating movies since 2007, and anti-smoking activists support a virtually automatic "R" rating for instances of on-screen smoking. Children under 17 are not allowed to attend "R" rated motion pictures unless accompanied by a parent or adult guardian. The MPAA issued an "R" rating for a recent film, "Its Complicated", due almost entirely to a brief scene in which the main characters smoke marijuana without adverse consequences. A. O. Scott, *This Article is Not Yet Rated*, N.Y. TIMES, Jan. 22, 2010, *available at* http://www.nytimes.com/2010/01/24/movies/24scott.html?pagewanted=1&hpw (last visited Mar. 16, 2010).

[91] *Id.*

animation "Fantastic Mr. Fox" is a villain.[92]

It is possible to construe the FCTC, going forward, as a framework for action in accordance with the bottom-up approach we urge. The Convention provides flexibility to do so, via the COP's authority to create future protocols and guidelines. Because the Guidelines are supposed to be informative and indicative of State Parties' intentions (albeit not legally binding), they can serve as effective means for promoting this approach. Scheduled guidelines for Articles 12 and 14 could make some progress on the awareness campaign front. Article 12 guidelines could emphasize the "benefits of the cessation of tobacco use and tobacco-free lifestyles as specified in Article 14.2."[93] If national anti-tobacco campaigns were to focus on ways to make tobacco use culturally undesirable – for instance by advocating for the portrayal of smoking as "uncool" in films and other entertainment vehicles – then an anti-smoking ethos could become more powerful in people's daily lives. Such an approach may work to reach youth who underestimate the risks of addiction;[94] people who understand the health consequences of tobacco use but fail to internalize or act upon them;[95] and citizens of countries where denormalization of smoking has been widely achieved, as is the case in the United States.[96]

Potential future guidelines for Articles 20 and 21 could make significant progress on the research and international collaboration fronts. Empirical findings should be the foundation of any bottom-up approaches to tobacco control based upon psychological realism. Article 20 requires State Parties to develop national research programs and to coordinate regionally and internationally with respect to the determinants and consequences of tobacco consumption.[97] Such research could more closely consider what causes people across cultures to smoke – and to exercise restraint. Article 21 mandates the dissemination of findings from this research, facilitating its translation into evidence-based policy.[98] Future protocols, as opposed to guidelines, would constitute an even more effective way to commit State Parties to tobacco control initiatives and obligations grounded in psychological realism. A future protocol, for example, could obligate developed countries to provide resources to less-developed countries for anti-tobacco campaigns sensitive to the psychology that drives both smoking and self-control.[99] Alternatively, countries could

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[92] *Id.*
[93] FCTC, *supra* note 2, art. 12(b).
[94] *See supra* note 55 and accompanying text.
[95] *See supra* note 61 and accompanying text.
[96] *See supra* note 81.
[97] FCTC, *supra* note 2, art. 20(1).
[98] *Id.* art. 21(1).
[99] Resource and capacity building is strongly needed in terms of tobacco control research and program implementation. *See, e.g.*, Frances A. Stillman et al., *Building Capacity for Tobacco*

be provided with incentives to pursue research into the psychological determinants of tobacco use and to develop pilot marketing campaigns based upon this new evidence. In sum, a number of coordinated bottom-up mechanisms have the potential to buttress and augment the existing WHO methods.

V. CONCLUSION

This Essay argues that tobacco control via the Framework Convention and its Guidelines should be pursued in more of a bottom-up fashion, sensitive to social norms, cultural cues, and conflicts within the self. These promising WHO legal and health policy instruments could benefit from greater psychological realism. Going forward, the FCTC and its accompanying guidelines and protocols should be used as tools to encourage State Parties to support their citizens' inclinations to resist tobacco's temptations. People's decisions to smoke (or to refrain) arise from competition within – competition between mental systems of perception and motivation that promote and discourage indulgence and self-restraint. Future protocols and guidelines should aim to take sides in this competition within ourselves. Alliances between government and myriad private actors – in manufacturing and commerce, entertainment, and other sectors – will be critical to this effort. So will funding mechanisms for research into the psychological determinants of tobacco use and for evidence-based public awareness campaigns that aim to take sides, gently, in the struggles within ourselves that lead to both indulgence and self-restraint.

Control Research and Policy, 15 TOBACCO CONTROL i18 (2006); Heather L. Wipfli et al., *Achieving the Framework Convention on Tobacco Control's Potential by Investing in National Capacity*, 13 TOBACCO CONTROL 433 (2004); Sebastián Albuja & Richard A. Daynard, *The Framework Convention on Tobacco Control (FCTC) and the Adoption of Domestic Tobacco Control Policies: The Ecuadorian Experience*, 18 TOBACCO CONTROL 18 (2009).

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