The Evolution of Smoke-Free Hospital Properties

The Growing Smoke-Free Trend

In recent years there has been an increasing number of bylaws regulating smoke-free outdoor spaces throughout Canada and especially in Ontario. Most of these prohibit smoking on municipal property, in parks, playgrounds and sports and recreational fields. Some municipalities prohibit smoking on restaurant and bar patios, which had become "the smoking section" once smoking was banned inside these establishments. Additional trends include governments starting to regulate smoking on private property, including in vehicles where children are present. Under the *Smoke-Free Ontario Act*, smoking is also prohibited at all times in private homes that operate as licensed daycares, and in private homes when home health care workers are present.

Many hospitals have chosen to implement smoke-free policies that go beyond the *Smoke-Free Ontario Act*'s requirement to prohibit smoking 9 m from entrances and exits[1,2] by prohibiting smoking on all property, including walkways and private vehicles in parking lots. In addition, seven Ontario municipalities have bylaws prohibiting smoking on hospital grounds.[3]

In 2009, Prince Edward Island set a Canadian precedent by becoming the first province to prohibit smoking on hospital property, although a psychiatric hospital was exempted with an outdoor designated smoking area for patients only.[4]

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[1] Government of Ontario. *Smoke-Free Ontario Act. How the Act Affects: Hospitals*. January 2007. http://www.mhp.gov.on.ca/en/smoke-free/factsheets/hospitals.pdf.

[2] Government of Ontario. *Smoke-Free Ontario Act, S.O. 1994, Chapter 10.* http://www.e-laws.gov.on.ca/html/statutes/english/elaws_statutes_94t10_e.htm.

[3] Elliot Lake, Mattawa, North Bay, Parry Sound, Peterborough, Sault Ste. Marie and Timmins. SHAF/NSRA *Smoke-Free Laws Database*. http://www.nsra-adnf.ca/cms/smoke-free-laws-database.html. Peterborough's bylaw is particularly noteworthy because it prohibits all tobacco use on hospital property, not just smoking. See *A Case Study: Peterborough's Leading Edge Bylaws* at http://www.nsra-adnf.ca/cms/file/files/Peterborough_Bylaw_Case_Study_2013-FINAL.pdf for details.

[4] Province of Prince Edward Island. *Chapter S-4.2, Smoke-Free Places Act*. http://www.assembly.pe.ca/bills/pdf_chapter/63/2/chapter-86.pdf.

Why Smoke-Free Hospitals?

There are several reasons commonly cited for a 100% smoking ban on hospital property:

- To protect patients, staff, volunteers and visitors from second-hand smoke (SHS),
- To promote healthy choices and provide a healthier environment;
- To reflect a hospital's health mission; and
- To be a leader in health promotion in the community.

A smoke-free workplace provides a supportive environment that helps employees who smoke to cut down or even quit smoking. Studies have demonstrated that a totally smoke-free workplace is associated with reductions in the percentage of employees who smoke and in the number of cigarettes smoked per day by those who continue to smoke.[5,6,7] In addition to benefitting the health of employees who quit, reduced smoking rates decrease absenteeism and increase productivity,[8] thereby reducing expenses for cash-strapped hospitals.

Smoking harms every organ of the body[9] and accounts for at least 30% of all cancer deaths[10] and half of all deaths from heart disease among Canadians under age 45.[11] Of particular importance to hospitalized smokers, smoking is also known to delay wound and fracture healing and cause wound site infections and other short- and longer-term postoperative complications.[12,13,14]

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[5] Bauer JE, et al. A Longitudinal Assessment of the Impact of Smoke-Free Worksite Policies on Tobacco Use. *American Journal of Public Health* 2005;95(6):1024–9.

[6] Frieden TR, Mostashari F, Kerker BD, et al. Adult Tobacco Use Levels After Intensive Tobacco Control Measures: New York City, 2002—2003. *American Journal of Public Health* 2005;95(6):1016–23.

[7] Fichtenberg CM & Glantz SA. Effect of Smoke-Free Workplaces on Smoking Behaviour: Systematic Review. *British Medical Journal* 2002;325(7357):188–94.

[8] The Conference Board of Canada. *Smoking and the Bottom Line: Updating the Costs of Smoking in the Workplace*. August 2006. http://www.conferenceboard.ca/e-library/abstract.aspx?did=1754.

[9] U.S. Department of Health and Human Services. *How Tobacco Smoke Causes Disease: The Biology and Behavioral Basis for Smoking-Attributable Disease: A Report of the Surgeon General.* Atlanta, GA: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health, 2010.

[10] American Cancer Society. *Learn About Cancer: Cigarette Smoking.* 2013. http://www.cancer.org/cancer/cancercauses/tobaccocancer/cigarettesmoking/cigarette-smoking-who-and-how-affects-health.

[11] Health Canada. *Smoking and Heart Disease.* 2012. http://www.hc-sc.gc.ca/hc-ps/tobac-tabac/legislation/label-etiquette/heart-coeur-eng.php#note6.

[12] Gill JF, Yu SS, Neuhaus IM. Tobacco smoking and dermatologic surgery. *Journal of the American Academy of Dermatology* 2013; 68(1):167-72.

[13] Al-Hadithy N, et al. The effect of smoking on fracture healing and on various orthopaedic procedures. *Acta Orthopaedica Belgica* 2012; 78(3):285-90.

[14] Sørensen LT. Wound healing and infection in surgery: the pathophysiological impact of smoking, smoking cessation, and nicotine replacement therapy: A systematic review. *Annals of Surgery* 2012; 255(6):1069-79.

"On any given day in Canada, over 23,000 hospital beds are being occupied by current smokers."[15]

The vast majority of smokers want to quit—one Canadian study reports the figure at over 90% of smokers,[16] while most U.S. estimates are in the 70% range.[17] Those who are hospitalized may have even more incentive to quit.

Quitting smoking is the single most important intervention for the prevention and management of major chronic diseases, including heart disease, stroke and cancer. Smoke-free hospitals create opportunities for better future health among smokers, but to be effective, hospitals need to do more than pass a simple policy banning smoking on hospital grounds.

The Key to Success: A Comprehensive Tobacco Policy vs. Smoke-Free Property

There is a big difference between a smoke-free hospital property policy and a comprehensive tobacco policy. A comprehensive tobacco policy recognizes the tobacco industry's role as the disease vector in the tobacco epidemic and acknowledges that it operates outside the boundaries of normal, ethical business. The tobacco industry has lied about the risks of its products, lied about addiction, lied about its manipulation of nicotine, lied about the risks of second-hand smoke, and lied that its marketing has not targeted kids. It might be a legal business (as is so often argued by Big Tobacco), but it is not a normal industry selling a normal consumer product. Indeed, half of all long-term users will die prematurely from their addiction to tobacco industry products—people who used the products exactly as intended by the manufacturer.

To help divert public attention from this abysmal track record, tobacco companies often use handsome donations to generate goodwill and to demonstrate corporate social responsibility. Donations can also help to forestall restrictive regulations that go against tobacco companies' interests. In addition, memberships on hospital boards and foundations, research grants and other types of targeted philanthropy can help to influence policies and create legitimacy.

As such, a comprehensive tobacco policy is a way for organizations to distance themselves from the tobacco industry and its products at every opportunity, and should be a goal for all hospitals.

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[15] Reid RD, et al. (2010). Smoking cessation for hospitalized smokers: An evaluation of the "Ottawa Model." *Nicotine and Tobacco Research* 2010; 12(1):11-8. As cited in University of Ottawa Heart Institute. *The Ottawa Model for Smoking Cessation: Best Practices for Clinical Smoking Cessation in Canada. The Ottawa Model for Smoking Cessation 2011-2012 Highlight Document*. http://www.ottawamodel.ca/documents/OMSC2011-12report.pdf.

[16] The Lung Association. *Making Quit Happen: Canada's Challenges to Smoking Cessation*. 2008.

[17] Centers for Disease Control and Prevention. Morbidity and Mortality Weekly Report (MMWR). *Quitting Smoking Among Adults--United States, 2001--2010*. November 11, 2011 / 60(44);1513-1519. http://www.cdc.gov/tobacco/data_statistics/mmwrs/byyear/2011/mm6044a2/intro.htm.

A comprehensive tobacco policy includes:

- Cessation support for staff;
- Cessation support for inpatients who want to quit (i.e., nicotine replacement therapy on the hospital formulary, as well as follow-up support with referral to community resources at discharge);
- Nicotine withdrawal management for inpatients who aren't ready/don't want to quit;
- A ban on tobacco sales and promotions on hospital property;
- An institutional ban on accepting tobacco industry donations, grants, funding for research projects, having any current or past tobacco company employee sit on the board of directors or any other committee, as well as a ban on any other type of arrangement or association;
- Divestment of tobacco industry stock; as well as
- A hospital property smoking ban. In fact, an emerging trend is a ban on the use of all tobacco products on hospital property, as is the case in Peterborough, Ontario.

The Non-Smokers' Rights Association / Smoking and Health Action Foundation is not currently aware of any hospitals that have adopted a comprehensive tobacco policy. However, the Ottawa Model for Smoking Cessation (OMSC) is a good example of how hospital-based smoking cessation for patients can be successfully accomplished. Developed in 2002 by experts at the University of Ottawa Heart Institute, the OMSC trains hospital staff to identify, treat, and provide long-term follow-up to help patients quit smoking and puts a system in place for all of these elements. The OMSC has demonstrated significant increases in long-term smoking cessation (6 months) and since 2006 has been adapted and implemented in 144 inpatient, outpatient, and primary care settings across Canada.[18, 19, 20]

Framing Tobacco Use: Habit or Addiction?

Tobacco use is highly complex, creating nicotine addiction in some people while causing only a psychological dependence in others. Thus a one-size-fits-all approach to the management of withdrawal symptoms for smokers trying to quit definitely does not work, making it even more difficult for hospital staff to deal with patients who smoke. Non-smokers may downplay the seriousness of nicotine addiction because everyone knows someone who quit overnight.

[18] University of Ottawa Heart Institute. *The Ottawa Model for Smoking Cessation: About OMSC*. http://www.ottawamodel.ca/en_about-TheOMSC.php.

[19] University of Ottawa Heart Institute. *The Ottawa Model for Smoking Cessation: Best Practices for Clinical Smoking Cessation in Canada. The Ottawa Model for Smoking Cessation 2011-2012 Highlight Document*. http://www.ottawamodel.ca/documents/OMSC2011-12report.pdf.

[20] Reid RD, et al. (2010). Smoking cessation for hospitalized smokers: an evaluation of the "Ottawa Model." *Nicotine and Tobacco Research* 2010; 12(1):11-8.

Framing tobacco dependence as an addiction has been found to result in health care providers being more inclined to understand the need for treatment to manage withdrawal symptoms.[21]

Unfortunately, smokers often receive suboptimal treatment in hospitals because the routine provision of interventions for tobacco dependence is not yet a practice norm. [22] In many hospitals, few staff, if any, have been trained to deal effectively with tobacco dependence. Nicotine withdrawal can make patients agitated and demanding, and frustrated staff may feel ill-prepared to deal with this.[23]

Implementation Issues

Regardless of what type of policy a hospital chooses to undertake, issues will arise that need consideration. Plans should be in place to deal with each of these before implementation.

Senior Management Champions

If a policy is not supported by upper management, it is unlikely to be successful. The senior management team must be involved from the beginning to send a clear message to staff and volunteers that they are expected to abide by the policy. In cases where a municipality passes a bylaw prohibiting smoking on hospital property, it must be embraced and championed by hospital management for optimal compliance, enforcement and ultimate impact.

Planning and Communications

Policy development and implementation takes time and must be well thought out. Implementing a policy over several stages rather than all at once may be a preferred strategy that can help to build support and compliance via extensive consultation. This is preferable to a policy that is rushed through without consultation, and then must be rolled back at a later date due to internal opposition and low compliance. It should also be noted that policies are living documents that need to be adapted periodically in response to scientific discovery and changes in social norms—a plan for annual or biennial review should be included in policy development.

There are several toolkits online that go through suggested steps and provide templates for communications, including information pieces for patients, staff and volunteers, as well as for signage. A useful toolkit is Sunnybrook's *Implementing Smoke-Free Property Policy in a Hospital Setting*.[24]

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[21] Schultz ASH, Finegan B, Nykiforuk CIJ et al. A qualitative investigation of smoke-free policies on hospital grounds. *Canadian Medical Association Journal* 2011; 183(18): E1334-E3144. http://www.cmaj.ca/content/early/2011/10/31/cmaj.110235.full.pdf.

[22] *Ibid.*

[23] *Ibid.*

[24] Sunnybrook Health Sciences Centre (no date). *Implementing Smoke-Free Property Policy in a Hospital Setting*. http://sunnybrook.ca/uploads/Sunnybrook_Smoke_Free_Policy.pdf.

Compliance and Enforcement Issues

While compliance is never perfect, it can be maximized by ensuring that the following steps/measures are taken:

- Consult with all stakeholders, especially during the planning and evaluation stages to help create a sense of ownership of the policy;
- Provide clear, regular and positive communications about the policy after adoption;
- Post adequate signage that clearly communicates where smoking is and is not permitted;
- Provide cessation support/withdrawal management for patients and staff;
- Train staff to provide cessation support/withdrawal management for patients that is integrated into every stage of their regular care, from pre- admission to discharge;
- Designate enforcement/security officers and train all staff on how to be ambassadors for the policy (including what they can say to patients and visitors who don't observe the smoke- or tobacco-free policy);
- Sweep up butts regularly to help visually communicate the policy; and
- Dedicate an adequate budget to support all of the above.

Additional Challenges

- The safety of patients who go off property to smoke is a concern. Hospitals need to be forthright in addressing this issue in their communications to patients, visitors, staff and volunteers, including responsibility and liability questions.[25, 26]
- Neighbours, especially in residential areas, may complain about tobacco-related litter, people smoking on their property, etc. Maintain open communications with all stakeholders and seek solutions collectively.
- Expansive hospital properties are not always convenient to leave for a quick cigarette, which may decrease productivity among staff.[27] In such cases, consider separate DSAs until a more comprehensive tobacco policy has been implemented.
- Staff, including security staff, may not feel comfortable enforcing the policy or may not see it as a worthwhile priority. Offer on-going staff training with opportunities for feedback and dialogue.

[25] Schultz et al. *Op.cit.*

[26] Schultz ASH. *Exploring Possibilities for Treating Tobacco Dependence: Expanding the Health Care Context of People Living with Lung Cancer*. In *Report Card on Cancer in Canada, 2011–12*. http://www.canceradvocacy.ca/reportcard/2012/Exploring%20Possibilities%20for%20Treating%20Tobacco%20Dependence.pdf.

[27] The Conference Board of Canada. *Smoking and the Bottom Line: Updating the Costs of Smoking in the Workplace*. August 2006. http://www.conferenceboard.ca/e-library/abstract.aspx?did=1754.

Recommendations

Given that cigarettes kill 50% of all long-term smokers, it is SHAF's position that at a minimum hospitals have a duty to implement one of the following smoke-free policies:

- Provide smoke-free buffer zones (at least 7 m) around doorways, operable windows and air intakes;
- Limit smoking on hospital property to outdoor designated smoking areas (DSAs). These should be tucked away from plain view and be located away from doorways, operable windows, air intakes, outdoor common areas and pedestrian routes. Significantly, there should be at least two geographically separate DSAs—one for staff and one for patients and visitors. There is something fundamentally wrong with hospital staff smoking alongside patients—an act that blurs professional boundaries and sends conflicting messages about the hospital's mission.
- Ideally, hospitals will make their grounds, including walkways and parking lots, 100% smoke- or even tobacco-free, as well as adopt more comprehensive tobacco policies that reflect the full societal impact of tobacco use.

Related Policy Issues

Third-hand Smoke

Third-hand smoke (THS), the chemicals that persist in the environment and on clothing and skin after a cigarette has been extinguished, is a relatively new concept in tobacco control. [28] As the research evolves on the health effects of exposure to THS, this will no doubt have an impact on future tobacco-related hospital policies. For example, staff that smoke may perhaps be restricted from working in the intensive care unit, or may not even be eligible for employment at all. This issue is already manifesting itself in the United States, where many health-related employers have adopted policies restricting employment to non-smokers only.[29] There are many ethical questions that relate to protection from THS, questions that likely won't be answered until the science is more definitive on the health risks of exposure.

E-Cigarettes

An electronic cigarette is a cylindrical device that mimics a cigarette in terms of appearance and use and sometimes taste, but does not contain tobacco. It is designed to deliver nicotine

[28] Ontario Tobacco Research Unit. *Glossary of Tobacco Control*. http://glossary.otru.org/glossary/all. Definition based on Winickoff JP et al. Beliefs about the effects of "thirdhand" smoke and home smoking bans. *Pediatrics* 2009; 123(1):e74-e79.

[29] Berman M & Crane R. (2008). Mandating a Tobacco-Free Workforce: A Convergence of Business and Public Health Interests. *William Mitchell Law Review* 2008; 34:1651-1674. http://publichealthlawcenter.org/sites/default/files/resources/tclc-symposium-berman-crane.pdf.

without subjecting the user to the toxic chemicals in tobacco and tobacco smoke.[30] As the use of e-cigarettes continues to increase in Canada, and as credible scientific research on their efficacy and safety emerges, hospitals will need to re-visit and update their smoke-free and tobacco-free policies. For example, policies that do not keep up with scientific discovery and public opinion will quickly become dated and poorly-received.

Conclusion

Hospitals have not escaped the gradually-unfolding paradigm shift regarding public attitude towards tobacco in this country. Canadians have a high level of awareness of the dangers of SHS and decreasing tolerance for exposure. There is increasing demand for smoke-free environments everywhere, including outdoors on hospital property. Many hospitals have responded to this demand with policies of varying degrees. Some Ontario municipalities have even passed bylaws to this effect, including Peterborough, which prohibits the use of any type of tobacco on hospital property.

However, hospitals need to recognize the important synergy between a smoke- or tobacco-free property policy and a comprehensive tobacco policy that not only addresses nicotine addiction among patients and staff, but also acknowledges the socially injurious nature of tobacco. Although many hospitals across Canada have adopted the Ottawa Model for Smoking Cessation, many patients who smoke continue to receive suboptimal treatment because the routine provision of interventions for tobacco dependence is not yet a practice norm. The SHAF is not aware of any hospital that has gone beyond these measures to adopt a truly comprehensive policy.

Given that tobacco use continues to be the leading cause of death and disability, every hospital in Canada has a duty to implement at least one of the policy measures outlined in this document. As social norms continue to evolve, and as new issues come to the fore, such as exposure to third-hand smoke and the use of e-cigarettes, smoke- and tobacco-free policies will need to be periodically re-visited to ensure that they remain relevant and consistent with hospitals' visions and missions.

[30] For a detailed description and analysis of e-cigarettes, consult the NSRA brochure *The Buzz on E-Cigarettes.* http://www.nsra-adnf.ca/cms/file/files/e-cig%20Brochure%20FINAL.pdf.