GOING SMOKE-FREE: ONE CANCER CENTER'S EXPERIENCE

Michael P. Eriksen, Sc.D.

This article describes the experience of the University of Texas M.D. Anderson Cancer Center in its implementation of a smoke-free policy. The author explains the planning process, how the impending policy change was communicated to staff and others, and how it is enforced.

A recent survey conducted by the Texas Hospital Association revealed that nearly 10 percent of Texas-based hospitals currently prohibit smoking, and another 30 percent are considering such a policy. One of the hospitals that is already smoke-free is the University of Texas M.D. Anderson Cancer Center, which became smoke-free on January 1, 1989, following a three-year planning process. The experience at M.D. Anderson provides a valuable example of how a large, comprehensive cancer center undertook the process of permanently changing a longstanding and accepted tradition. The M.D. Anderson experience can serve as a model for other large health care institutions, as well as other business organizations that are considering becoming smoke-free.

What the Policy States

The Cancer Center's smoking policy is an official element of the administrative policies and procedures of the institution. The policy reads as follows:

"The University of Texas M.D. Anderson Cancer Center is committed to the health of its patients, their families, and its employees; therefore, this institution became smoke-free on January 1, 1989. No employee is allowed to smoke on institutional property after this date. This policy also applies to the use of smokeless tobacco products."

There were two distinct objectives in establishing the institutional smoking policy. The first objective was to protect the health and well-being of nonsmoking patients, family members, and employees from exposure to environmental tobacco smoke. The second objective was to make a clear and unambiguous statement, as a cancer center, against the use of tobacco.

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There are a number of aspects of the smoke-free policy that should be elaborated. First of all, the policy prohibits smoking on all institutional property. This includes not only the interiors of buildings, but the institutional grounds as well. This provision was included in the policy to prevent smokers from congregating just outside the major entrances to the hospital. Because they must leave institutional property to smoke, smokers most often go to the public sidewalk or to nearby parking garages.

Second, the smoke-free policy applies to all individuals on institutional property. This means that employees, patients, family members, visitors, volunteers, and anyone else on M.D. Anderson property is prohibited from smoking. The only exception to this rule is referred to as the "compassionate exception," which enables a staff physician to write a medical order in a patient's chart that allows the patient to smoke in a private room or in a room with another smoker. The intent of this exception is to avoid those rare instances where the patient is so nicotine dependent that refraining from smoking would be, in itself, a medical hardship, and would negatively impact the patient's therapy.

The "compassionate exception" was intended to be used sparingly, and it is providing needed policy flexibility for both the patients and the medical staff. According to the current Surgeon General's Report, in a hospital in Minnesota, the medical exception was used only 10 times during the first 18 months of the policy.

The Planning Process

In 1986, an institutional task force recommended that the M.D. Anderson Cancer Center become smoke-free by January 1, 1991. This recommendation acknowledged that going completely smoke-free would require an adjustment period for smokers to either alter their smoking patterns or to seek employment elsewhere if they felt they would not be able to comply with the policy. When the five-year, smoke-free goal was announced, the restrictive smoking policy that prevailed at that time was made more restrictive. Smoking was prohibited in open space work areas and restricted to designated smoking areas (designated bathrooms throughout the hospital and sections of the cafeteria).

While the 1986 action and the five-year, smoke-free goal tended to reduce nonsmokers' exposure to second-hand smoke, a number of problems continued to exist, which is typical of partial solutions. Nonsmokers complained when the bathroom next to their office was designated as a smoking bathroom, and smokers complained that there were not enough smoking areas. At the same time, employees were raising the question of why it was taking so long to become smoke-free.

The impression was that because the date was so far in the future, smokers were not taking the policy seriously, and were not using the time to prepare for the eventual smoke-free policy.

In 1988, based on these types of comments, the Smoking Policy Implementation Committee recommended to the Executive Committee of the Medical Staff that the effective date of the smoke-free policy be moved up from January 1, 1991, to January 1, 1989. The Executive Committee concurred with this recommendation and obtained the support of the President, Dr. Charles LeMaistre. In May of 1988, it was announced that as of January 1, 1989, M.D. Anderson would be a smoke-free institution.

In this planning process, the support of top management was essential. As a member of the original 1964 Surgeon General's Committee, and advocate of nonsmoking, President LeMaistre clearly was supportive of the creation of a smoke-free institution. It was the decision of the Smoking Policy Implementation Committee, in response to employee input, to move up the effective date of the policy by two years. This type of independent committee work, coupled with executive support, facilitated the planning and implementation of the policy.

Communication Efforts

Once the decision was made to advance the effective date of the policy, the establishment of an effective communications campaign was essential. The institutional Office of Public Affairs embraced the smoke-free policy as a major communications project and developed a comprehensive communications plan that included messages and materials for both internal and external audiences.

All existing internal channels of communications were used to inform employees, patients, visitors, and volunteers about the upcoming smoke-free policy and associated smoking cessation programs. Existing and regularly published print media included articles on the smoke-free policy and specialized print pieces were developed, such as brochures, memos, table tents, and posters, to communicate specific aspects of the policy. In addition, a meeting for all managers was held to inform them about their responsibilities in implementing and enforcing the policy, and to provide an opportunity to have their questions answered.

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Externally, referring physicians and institutional vendors were notified of the effective date of the policy and press releases were provided to the media to keep them informed. As a result of going smoke-free, every major media outlet in Houston, both print and broadcast, covered the story about how and why M.D. Anderson was going smoke-free. In addition to local coverage, the smoke-free policy was covered by *USA Today* and the Cable News Network.

Policy Enforcement

Fair and consistent enforcement is critical to the success of a smoke-free policy. To that end, the following statement is included in our institutional administrative policies and procedures manual:

"Enforcement of this policy will be handled like other institutional policies. Any infraction of the non-smoking regulation is subject to disciplinary action up to and including discharge."

To fairly and consistently enforce a smoke-free policy, it is recommended to develop separate procedures for employees and for all others who are required to comply with the policy.

Enforcement and compliance for employees is relatively straightforward compared to that for patients, visitors, and others. Smoking policies can be established as part of the employer-employee relationship; that is, enforcement of the policy is considered the same as it is for any other institutional policy. This is the approach taken at M.D. Anderson, and it is also the approach adopted by the majority of private corporations that establish restrictive smoking policies. Because of this existing relationship, there are channels already established for communications, and mechanisms in place for disciplining instances of noncompliance. While most institution's progressive discipline policies can lead to termination as a result of repeated policy violations, no instance of an employee being terminated as a result of violating a smoking policy has been reported.

While enforcement for employees is clear-cut and existing mechanisms can be used, the same is not the case for patients, visitors, and volunteers with whom the hospital does not have the same type of formal relationship. Therefore, the concept of progressive discipline is irrelevant when dealing with patients or others who may be violating the policy. At M.D. Anderson, the support of the University of Texas police was enlisted to help enforce and ensure compliance with provisions of the policy. The police staff were trained on the details of the policy and they were encouraged to use tact and courtesy in dealing with

Creating a smoke-free hospital

M. D. Anderson, in conjunction with the Physician Oncology Education Program of the Texas Medical Association, recently conducted a one-day conference on "Creating Smoke-Free Hospitals." This conference was attended by nearly 40 Texas-based hospitals that are actively considering smoke-free policies. Besides presenting the M.D. Anderson experience, participants were made aware of two sets of guidelines designed to assist hospitals in becoming smoke-free. The first package, "Clean Air Health Care" was developed in 1986 by the University of Minnesota. Copies are available from Doctor's Helping Smokers (612/625-5436). The second package, "Smoking and Hospitals Are a Bad Match," (catalog no. 166901) was developed by the American Hospital Association, and is available at $18 for AHA members and $35 for nonmembers (1-800-AHA-2626).

patients and visitors found smoking on M.D. Anderson property. Prior to implementation of the policy, brief one-page fliers were prepared for the police officers to give to anyone seen smoking on the grounds of the institution, which informed them of where they could smoke and about the impending smoke-free policy.

Since the enactment of the policy, police officers politely ask anyone who is seen violating the policy to extinguish their cigarette in accordance with institutional policy. To date, this strategy has been successful and there have been no incidents where any additional action has been required.

Overall, compliance with the institutional smoke-free policy has been outstanding, although not perfect. There are still occasional reports of smoking in stairwells or in bathrooms. However, the overall objectives of the smoke-free policy have been achieved.

Smoking Cessation Programs

To increase the acceptance of a smoke-free policy, it is important to offer smoking cessation options, particularly for employees, and, ideally, to all who are affected by the policy. The availability of smoking cessation opportunities, particularly if they are subsidized and offered, at least partially, during work hours, sends a strong message to employees that while the institution is restricting where smoking can occur, it is also making a financial commitment to help employees who would like to quit.

While the availability of smoking cessation programs will aid in the acceptance of the smoke-free policy, actual participation may be disappointing. Although according to national surveys, most smokers would like to quit smoking if there were an easy way, most do so on their own and few tend to enroll in organized programs. At M.D. Anderson, programs were financially subsidized, offered during work time, and extensively promoted to employees. Even with this level of effort, only 24 out of an estimated 750 smoking employees participated in organized smoking cessation groups. Another 118 sets of self-help materials were requested.

Summary

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Overall, the smoke-free policy at M.D. Anderson can be considered a resounding success. While compliance may not be 100 percent, our two specific objectives have been met: the air quality is noticeably improved; and there have been no dismissals, resignations, or legal actions, attributable to the policy. We estimate that, excluding staff time, it cost approximately $13,000 to prepare the communications materials, purchase the smoking cessation materials, and develop the smoke-free signage. We consider this modest expenditure to be a wise investment and would encourage all hospitals to consider becoming smoke-free. ■

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FROM THE EDITOR

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Fourth, there is no question that ACCC and state organizations need to work together. In Michigan, oncologists were initially caught off guard and had to organize as they went along. There were no precedents and there were many interested parties, all of whom were attempting to ensure that their individual perspectives were reflected in the legislation. An important function of ACCC is to facilitate the exchange of experiences among state organizers. Michigan could have used some of the support that ACCC intends to provide to state organizations, including coordination with national organizations, suggested legislative language, grants to help underwrite educational efforts, and so forth. Certainly, ACCC needs state-level, front-line involvement to know whether proposed compromises will work; whether or not various players are trustworthy; and to build local support among legislators, agency officials, and the press.

We need to build a national organization that has strong, state-level components to resolve problems. Without our mutual efforts, we will suffer a loss of experience and insight, we will not have the best resources, and we will not make the best use of the resources we have. There are too few of us, with far too limited resources, to end up squabbling amongst ourselves. We need to build strong bonds at the community oncology level, and we need to balance good faith with specific legislative language.

We will continue to monitor the situation in Michigan with the recognition that a change of heart by the Blues could destroy the fragile faith that is being built. Our presumption, for now, is that good faith will work in Michigan. However, just because you are paranoid doesn't mean that you are not being followed around. In other words, some paranoia is healthy in these times of rapid change.

(Prepared in collaboration with John Burrows, M.D., President, Michigan Society of Hematology and Oncology.)

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