Hospital Topics

Hospital action on smoking

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British Medical Journal, 1979, 2, 777-778

"This circular gives new and more explicit advice on discouraging smoking in hospitals and other health premises. It emphasises the exemplary and educational roles of health professionals and the need for policies on smoking in all health premises including consideration of a ban, save for long-stay patients, on the sale of cigarettes on the premises."

This summary of *Non-Smoking in Health Premises*¹ from the DHSS, although not couched in the most exciting language, was actually a call for action addressed to regional health authorities, area health authorities, boards of governors, and family practitioner committees. The following is a report of action taken at one hospital, the Central Middlesex.

Action taken

The medical division first considered the circular to see what should be done. A recent survey at the hospital had shown that 89% of inpatients thought that smoking should be restricted in the wards and 76% that specified smoking areas should be set up in the hospital. These results were similar to those of the *Which?* survey,² which had shown that 68% of smokers and 76% of non-smokers thought that smoking should be banned in hospital wards. As a result certain recommendations were sent to the district management team (DMT). These included: non-smoking should be the normal practice in acute wards; specified areas should be set aside for those unable or unwilling to stop; and non-smoking should be the rule in all public areas of the hospital.

The DMT referred the matter to the staff representative group, which set up a working party consisting of a clerical officer, the fire officer, representatives of the ancillary and of the professional and technical staffs, a staff nurse, and a doctor. They agreed to the following principles.

- (1) No smoking should be the normal practice in all acute wards.
- (2) Special areas should be set aside for those unable or unwilling to stop.
- (3) No smoking should be the rule in all public areas in the hospital.
- (4) Hospital staff should not smoke in the presence of patients or visitors.

(5) Visitors should not smoke except in defined areas outside the ward.

(6) All canteens should have separate areas for smokers and non-smokers.

Recommendations about tobacco sales were not necessary since for the previous five years cigarettes had not been sold in the hospital shop or on ward trolleys.

These principles were agreed by the DMT. Discussion and consultation had by this time taken over a year. Signs depicting the crossed-out cigarette were placed at all hospital entrances and entrances to the wards. Scottish Health Education Unit signs "You are entering a no-smoking area" and "You are in a no-smoking area" had also been widely used. "Smoking allowed here" notices were sited in appropriate places. Fortunately, the district administrator, the chief nursing officer, and the hospital secretary all strongly supported the action.

To start the new policy and inform all staff and patients it was decided to hold a "smoking action week" in September 1978. Encouraging messages were received from Mr David Ennals as well as from Mr Patrick Jenkin, who was then Conservative spokesman on health. The week was opened at a meeting addressed by Sir George Young, the MP for Acton and Ealing, and now parliamentary undersecretary of state at the DHSS. He gave strong support to the campaign and promised that he would press the Government to take stronger steps against smoking. During the week the Thames Television film *Dying for a Fag* was shown at lunch-time meetings for staff and patients. It portrays a 41-year-old soldier's reaction to developing lung cancer and has been widely and effectively used in Norway and many other countries.

The local health education officer arranged suitable poster displays, and leaflets on giving up smoking were placed at strategic points and were rapidly picked up. A feature article on the campaign was produced in the *Brent Goose*, the local hospital magazine. At the end of the week staff and patients were invited to attend an informal discussion on ways of helping them to stop smoking. The public relations officer of the regional hospital board distributed press releases and as a result considerable cover was given in the local and national press, and also on local radio.

What did the campaign achieve?

Evaluation has been difficult. The hospital population changes rapidly: in a month most patients have gone, and in six months many staff have changed. Nevertheless, no patient or visitor entering the hospital can now be unaware that smoking is allowed only in certain areas. Ward sisters were asked what effect the campaign had had; replies varied from considerable to none. A few patients had discharged themselves when told they could not smoke in the ward, but a tactful approach and if necessary a shift to a ward corner can usually resolve such a problem. One sister complained that doctors were the worst offenders when they smoked in ward offices. Porters and nurses who smoke also limit the effectiveness of hospital policy.

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An agreed hospital policy on smoking is certainly of value. We hope that an important result has been a change in attitude about smoking by some of the staff. Undoubtedly a no-smoking policy on a ward works if the sister in charge accepts it and takes action, and the doctors give their full support. This has been our experience for many years on the wards for patients with chest and heart diseases. Complaints about restrictions have been very few, and many smokers have stated that they appreciated coming into a non-smoking ward as it helped them to abstain. No one denies that cigarette-ends are often found outside the lavatory windows—but the air in the ward is generally smoke-free.

The freedom of the smoker should no longer take precedence over that of the non-smoker who wishes to be nursed in a smoke-free atmosphere. The smoker who cannot or will not stop should be asked to go to an area where smoking is allowed. Smoking patients with incurable disease or psychiatric illness can often be nursed in a side room or corner of the ward.

At present long-stay wards, especially those with psychiatric or geriatric patients, need different handling, since it would be unreasonable to restrict smoking to the same extent. The rights of the growing number of older non-smoking patients should be considered, however, and where possible a non-smoking area should be available for them.

Fire risk should also be remembered when producing a hospital smoking plan. Smoking is the leading cause of hospital fires, especially in geriatric and psychiatric wards. The number of hospital fires in Britain doubled between 1968 and 1972, and in 1974, 27% of fires were caused by smoking. More fires occur in the wards than in other parts of the hospital. The risk may be lessened by defining smoking areas rather than by an absolute smoking ban, which may lead to subterfuge and hence riskier smoking. In such areas fire-resistant materials should be used.

It is difficult to see why the authorities at any acute general hospital should still allow the sale of cigarettes. A survey in 1976 of 83 large hospitals, including 62 teaching hospitals in Britain,

showed that 72% sold cigarettes in hospital shops and 47% on ward trolleys, and there were similar findings in Scotland. Where the shops are run by independent contractors, stopping sales may be difficult until the contract expires. New contracts should not allow tobacco sales. Where the League of Friends, the British Red Cross, or the Womens Royal Voluntary Service manage the shops and trolleys there should be no difficulty in asking them to desist, since all three national bodies have agreed not to sell cigarettes if asked by the hospital authorities not to do so. Visitors can always supply cigarettes, and we have had few complaints since stopping cigarette sales in our own League of Friends shop. Profits fell slightly for the first year but since then have continued to rise. Insurance premiums for premises carrying cigarette stocks are considerably higher than where none are held.

Conclusions

Britain produced the first major report on the hazards of smoking 17 years ago, and this received worldwide attention. Although today we lag behind many countries in attempts to reduce smoking in public places, in a growing number of stores, transport vehicles, and public buildings smoking is either forbidden or restricted. Most people, including both smokers and non-smokers, favour a ban on smoking in hospital wards. It is surely time for doctors and hospital authorities to show a greater sense of urgency in controlling this lethal habit.

References

- ¹ Department of Health and Social Security, Health Services Management: Non-Smoking in Health Premises, HC(77)3. London, DHSS, March, 1977.
- ² Consumers' Association, *Which?*, 1975, February, p 56.

The manufacturers of TAB vaccine admit that the value of the paratyphoid component has not been established. Monovalent typhoid vaccine is effective against typhoid fever and causes fewer reactions than TAB vaccine. Should the profession change its standard vaccination procedure?

The questioner is quite correct, and the standard typhoid vaccination procedure has now tended to become two doses of 0.5 ml of the monovalent typhoid vaccine given subcutaneously with an interval of about one month. This is an effective vaccine against typhoid fever and causes much less reaction than the TAB vaccine. It is thought that there is a 70-80% protection with the monovalent vaccine, and after a primary course immunisation lasts for three years.

What harmful effects are supposed to arise from the inhalation of the amounts of formaldehyde and xylol commonly present in laboratory atmospheres, and what is the evidence for their toxic effects?

Both formaldehyde and xylene are irritant to mucous membranes. As little as 5 parts per million (ppm) of formaldehyde cause lacrimation and irritation of the nose and throat and 10-20 ppm coughing and difficulty in breathing. The few reports of any appreciable effect suggest that individual susceptibility is important, and susceptible individuals, who may be atopic or non-atopic, may develop slightly decreased pulmonary function, asthma,¹ or pneumonitis.² Exposure to xylene fumes may be more prolonged and may produce various symptoms, such as headache, dizziness, shortness of breath, irritation of the eyes and throat, and respiratory and gastrointestinal symptoms. More serious effects—for instance, liver damage and blood dyscrasias—may be due to contaminating benzene. The maximum allowable concentration in the air in the USA is 100 ppm, whereas in Russia it is only 11 ppm.² Provided that small, confined laboratories are avoided, normal ventilation should keep the concentrations of both vapours

down to acceptable levels. Assisted exhaust ventilation may be needed if susceptible individuals must work in a formaldehyde-contaminated atmosphere. Anyone undertaking slide-staining, however, will be in close proximity to concentrations of 100 ppm or more of xylene for short periods, during cover slipping for example,² so that provision of exhaust hoods for operations in which xylene dishes are opened to the atmosphere is wise.

- ¹ Hendrick, D J, and Lane, D J, *British Journal of Industrial Medicine*, 1977, **234**, 11.
- ² Porter, J A H, *Lancet*, 1975, **3**, 603.

³ Bush, C L, *Laboratory Medicine*, 1977, **8**, 16.

What advice can be given to a patient who suffers from the severe dry mouth of rheumatoid arthritis and finds it difficult to keep in an upper set of dentures, even after using a proprietary fixative?

Severe dry mouth combined with rheumatoid arthritis occurs in Sjögren's syndrome, and poor denture retention is a common complication of diminished salivary flow. The xerostomia of Sjögren's syndrome results from irreversible changes in the salivary glands, and attempts to stimulate secretion by, for instance, sucking boiled sweets are unlikely to be successful and artificial saliva may be necessary. There have been many attempts to produce a satisfactory saliva substitute. One simple formulation that has helped some patients was derived from the work of Ashurst¹ and consists of gum tragacanth 60 mg and chloroform 15 ml. The solution is rinsed around the mouth for about one minute and then expectorated. It lubricates the tissues as well as, it is hoped, helping the retention of a denture. Repeated use throughout the day may be necessary. Finally, the denture must fit accurately against the tissues and a good peripheral seal must be developed.

- ¹ Ashurst, P, *British Journal of Dermatology*, 1968, **80**, 124.