Questions and Answers

The following discussions all relate to preventive medicine. Those on tobacco and health (chosen from among many received) were referred to Alan Blum, MD, who has written frequently on this subject.

Smoking Guidelines for Hospitals

Q A recent COMMENTARY in THE JOURNAL (243:739-740, 1980) suggested that physicians should be active in the prevention of smoking-related problems. Are there specific guidelines for a rational smoking policy for hospitals? For example, should smoking be allowed in patients' rooms? Should visitors be allowed to smoke? Your help would be appreciated.

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A "60 Flee Fire at VA Hospital; Smoking Blamed" reads a headline in the May 6, 1980, issue of the *Chicago Tribune*. Unfortunately, such headlines are all too common. It is essential to remember that in the hospital setting, smoking is as much a fire problem as a health problem. According to the Joint Commission on Accreditation of Hospitals (JCAH)[1] smoking is responsible for approximately 60% of the estimated 1,500 annual *reported* hospital fires. (The next leading cause, faulty electrical wiring, is responsible for 20%.) Moreover, fires present a greater danger in health care facilities than in other environments because of the number of incapacitated patients who are unable to escape.

Although the JCAH suggests that all hospitals adopt and enforce a strong set of smoking regulations, their publications on the subject (eg, *1980 Accreditation Manual for Hospitals*, p 45) are almost entirely concerned with containing rather than preventing fires. Only seven specific recommendations are made regarding smoking, such as the following: "Patients who are confined to bed should be discouraged from smoking," and "Ashtrays shall be noncombustible."*

A review of the medicolegal aspects of hospital fires noted that "fire in a hospital is one of those potential disasters about which the hospital is obliged to be constantly on guard."[2] Failure to adhere to "reasonable standards," as a result of which a patient is burned in a fire for which he was not responsible, probably would make the hospital liable without further proof of negligence.

If a hospital prohibits smoking in all but a few specially designated areas, it should advise its insurance companies, so that fire insurance premiums can be lowered accordingly.

Bolstered by the increasing evidence of the adverse effects of secondhand smoke, a few hospitals, eg, Central Middlesex Hospital, London (*Postgrad Med J* 49:682-683, 1973), and several US hospitals, have established no-smoking wards and have tried to encourage more exemplary educational roles for health professionals. The overriding principle in the newer policies is that nonsmoking should be the rule in all public areas of the hospital unless otherwise specifically indicated.[3,4] The following guidelines patterned after those proposed by the Public Citizen's Health Research Group[5] could serve as a model: Ban the sale of cigarettes, cigars, and pipe tobacco in hospitals and on hospital grounds. Ask all patients before admission about their preference for a smoke-free ward and guarantee that preference. Ban smoking from all corridors and elevators. Restrict smoking of tobacco in the hospital to specifically designated rooms. Require the hospital to put its smoking policy in writing and send to all employees and prospective employees.

Administrators and chiefs of staff can develop positive incentives for the perpetuation of such a policy. These can include the posting of nonthreatening signs at all entrances and in corridors, as well as publishing the policy throughout the community at large. Enforcement should be assumed equally by administration, health professionals, and employees, the underlying philosophy being that a hospital is not just another place of work, but, rather, a place dedicated to health.

Above all, a strong nonsmoking policy in hospitals can add significantly to cost containment. More and more companies have found that even after doling out cash bonuses to those employees who choose not to smoke, an overall saving is created by lowered levels of absenteeism, sick leave, and medical insurance premiums.

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The JCAH welcomes discussion on this issue. Address correspondence to Helen Johnston, MD, Joint Commission for Accreditation of Hospitals, 875 N Michigan Ave, Chicago, IL 60611.—ED.

1. JCAH Fire Safety Requirements Explained. *Perspectives on Accreditation*, March-April, 1980. Chicago, Joint Commission on Accreditation of Hospitals.
2. Holder AR: Hospital fires. *JAMA* 231:281-282, 1975.
3. Ball K, Stevenson A: Hospital action on smoking. *Br Med J* 2:777-778, 1979.
4. Brosseau BLP: Hospitals must stop pushing tobacco. *Dimens Health Serv* 54:5, 1977.
5. Fishman L: More rights for airline passengers than for hospital patients: A report on smoking policies in metropolitan Washington, DC, hospitals. *Hosp Admin Curr* 21:24, 1977.

'Single-Day' Treatment for Smoking Cessation

Q Dr Neil Solomon, in a syndicated newspaper column, wrote that he injects a solution of vitamins, minerals, and procaine on each ear and alongside the nose of patients who want to stop smoking. He claims that the effect is immediate after four injections of this solution. What is your opinion about this so-called single-day treatment for smoking cessation? Is there any proof that it works?

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Among others inquiring about this treatment were Thomas P. Kennerly, MD, Houston; Jim J. Chow, MD, Manistique, Mich; and J. C. Mowrer, Jr, MD, Rochester, NY.

A In 1979 the Internal Revenue Service (IRS) denied an individual the right to deduct the cost of a smoking-cessation course—a correct ruling but for the wrong reason. The IRS did not note (and may not have known) that no single method of smoking cessation has an especially high or long-lasting success rate. (Most methods show less than a 25% success rate after six months.) Rather, the tax collectors did not want to define

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