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A Hospital without Tobacco: Utopia or Fact?

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1. Abstract

The Law 1799 on Tobacco Control, passed by the Legislative Body of the Autonomous City of Buenos Aires, on September 29th, 2005, was a significant advancement in the fight against smoking in our City of Buenos Aires.

However, in the field of Hospitals that depend on the Ministry of Health of the Government of the City, the rule is far from being met.

In this lecture we review the grounds that support the existence of guidelines of this nature, the tobacco-dependent pathology that is the cause of a huge expense for the Health Care System, and the steps that should be taken for the law to be really feasible, since its mere existence is no guarantee.

The conclusion is that if no concrete steps are implemented with a corresponding audit and follow up by the proper control organizations, the goal of tobacco-free Hospitals will not be easily achieved.

A Hospital without Tobacco: Utopia or Fact?

2. Introduction

The Law 1799 on Tobacco Control, passed by the Legislative Body of the Autonomous City of Buenos Aires, on September 29th, 2005, was a significant advancement in the fight against smoking in our City of Buenos Aires.

Five years after the law was passed, it is common to see that people comply with it in bars and coffee-shops, buildings and public buildings, companies, and it is even possible to see in many families that live with smokers, that the latter withdraw to open areas when they need to smoke and want to do it.

In the environment of our Hospitals, it is possible to observe a contradictory, and even paradoxical phenomenon, beyond the limitations entailed by the law as it was passed, as it permits smoking in Mental Health Hospitals and open areas (such as yards) that many Municipal Hospitals have.

Such phenomenon mentioned here, is that in general, it is easy to verify that the public coming to receive medical care, or accompanying patients, or visiting admitted patients, comply with not smoking within the hospital; while part of the staff in any category (professionals and nonprofessionals) is still smoking.

This is what was observed by members of the "Smoking or Health" Program, of which both authors are part in different institutions in the city.

This fact shows that the goal of achieving Tobacco-free Hospitals goes beyond complying with the law, and it cannot remain unwatched; on the contrary, it should be accompanied by an active policy to achieve what is stated in the passed law, as we will try to develop in this manuscript.

3. Background

More than 50 years have gone by since Richard Doll communicated in the British Medical Journal, the indisputable relationship between lung cancer and the so-called considered *habit* of smoking.(1)

In the half a century that elapsed since that hallmark publication and more than 40 years after the first report of the General Surgeon of USA in this regard, a new updated report(2) informs about a powerful database that contains more than 1,600 literature references summarizing the ravages caused by smoking on the health of those affected by this pandemic, the most important one known in the 20th C, and most certainly in this century(3). To the awful list of consequences, diseases such as leukemia, cataracts, pneumonia, cervical, kidney, pancreatic, and stomach cancer are added.

This database was patiently built by the Institute for Global Tobacco Control at the Bloomberg School of Public Health, Johns Hopkins University and the Centers for Disease Control and Prevention's Office on Smoking and Health of USA.

According to this report by the General Surgeon, 440,000 USA citizens die every year as a consequence of smoking, and in average the men affected live 13.2 years less than

nonsmokers; while women die in average 14.5 years before nonsmoking women. In economic terms, every year 157 billion dollars are devoted in USA to cover the emerging expenses for this pathological behavior -75 billions as direct medical costs and 82 billions as loss of productivity-.

In year 2000, the WHO estimated that 4,000,000 people died as a consequence of tobacco-dependent diseases, half coming from developing countries, and it predicts for year 2030 that near 10,000,000 people will die every year, a 70% of which will be native from developing countries such as ours.(4)

A report from the Ministry of Health of our country, available on the Internet,(5) informs that 40,000 Argentine people die every year as a consequence of tobacco; that our country is at the top of tobacco consumption in the whole of Latin America with the alarming figure of 40% of the population affected by this addiction, according to different prevalence studies that agree on this; and that a third of our teenagers have started to consume tobacco.(6)

Tobacco-dependent pathology

This is as varied as the range of diseases related to tobacco addiction. There is virtually no organ in our body that is spared from suffering a related pathology.

From this point of view, a simple reasoning would let us deduce the huge effort that approaching these pathologies entails for the Health Care System; needless to say these diseases are extremely prevalent. Since the General Hospital of Acute Diseases is a very important part of the Health Care System, it is evident that a large part of the resources of all types required by it, should be devoted to providing care for these diseases. Just by remembering the close relationship between cardiovascular disease and cancer with smoking, what we state here immediately becomes an incontestable fact.

It is then necessary for the Health Care System to undertake steps leading to face tobacco-dependent pathologies as a block, just as it is done at hospital level with other types of etiologies, such as infections. In this merely etiologic aspect, if tobacco consumption in all of its forms is the cause of a disease, such as bacteria, viruses, racketzias, fungi, and so on, are too for infectious diseases, we could state that our hospital system is placed in the struggle against this plague, in a stage we could

consider as *pre-pasteurian* to tackle this complex nosology that starts with the addiction to nicotine, even after passing the abovementioned law. However, we do now have this powerful instrument that acting synergically with steps that will be explained here and jointly with the offer of specialized medical offices to provide care for addicted patients, would enable results that would lead to Health in the whole population and a superlative improvement of the health care system as a whole.

For this reason it is convenient to analyze jointly the diseases produced by smoking and the usual form of tobacco consumption; i.e. smoking cigarettes.

Cardiovascular diseases

They constitute the main cause of death in our country, just as it happens in most. Smoking is, along with dyslipidemia, hypertension, and diabetes, one of the main risk factors to suffer them. Coronary artery disease, stroke, or peripheral vascular disease are much more prevalent between smokers, and even more so when smoking is associated to one of the others. Thus, nearly a 40% of more than 1,200 patients that were admitted with acute myocardial infarction in our study made in Uruguay, were smokers.(7) Similar findings are reported in another study conducted in the Unit of Epidemiology and Public Health of the School of Medicine and Department of Cardiology (University Clinic) of the University of Navarra.(8)

The bibliography supporting this is endless.(9,10)

The situation in our country, and since it strikes close to home it is all the more eloquent, is in turn terrible.

Surveys conducted by the Council of Emergencies of the Argentine Society of Cardiology showed that in 1991, 37% of infarcted people were smokers. The figure increased in 1996 to 48% and in 2000 to 48.5%.

In a retrospective review of clinical histories performed in 125 in- and out-patients from the Service of Cardiology of the *Hospital de Clínicas* between January 1st and June 30th, 2000, it was found that the most prevalent risk factor was hypertension, and smoking came second.(11)

Multiple studies clearly showed that cigarette consumption increases the risk of CV disease. Such risk is related to the number of cigarettes, the precocity of the habit, and

the type of tobacco. When smoking is quitted, the risk of CV disease decreases by a 50% on the first year, and it gets closer to that of nonsmokers after from 2 to 10 years. (12)

Nontumoral respiratory diseases

Smoking is the most important etiologic agent for these respiratory diseases, to the extent that we can state that 90% of bronchitis are due to this cause. Emphysema, COPD, find in nicotine addiction their main cause. Likewise, the incidence of coughing and phlegm between smokers is three times greater between smokers than between those who are not. The same occurs when measuring pulmonary function.(13,14,15)

There is a direct relationship of the dose-response type between these pulmonary diseases and cigarette consumption. This is to say, the greater the number of cigarettes smoked daily, and the greater the exposition measured in years of consumption, the greater the risk of suffering them.

Smoking and cancer

The following figures of relative risk speak by themselves regarding the close relationship between tobacco addiction and cancer in several areas. In the lungs, the HR is 3.6 to 16.0; in the larynx 6.0 to 13.6; in the mouth 1.1 to 13.0; in the pharynx 2.9 to 12.4; in the esophagus 0.7 to 6.8; in the bladder 0.9 to 5.9; in the pancreas 1.5 to 3.2; in the kidney 1.0 to 1.5; and in the cervix 1.2 to 3.

There is a relatively recent publication coming from Japan, which tells about the high risk of death due to hepatocellular carcinoma in smokers and former smokers in comparison to those who are not.(16)

Finally, tobacco consumption accounts for 30% of all cancer deaths.

Smoking and health problems in women

It would not be an exaggeration if we were to state that nowadays, but mostly in a near future, smoking is becoming a predominantly female disease. Those clichés that a few decades ago attempted to associate smoking with feminism, are achieving today for tobacco to be the main cause of death in women. It is terrifying to think on the fact that

a third of current female teenagers will die in the next years as a consequence of a tobacco-dependent disease.

Deceptive publicity helps in this, aiming at young people and women, depression, stress, and the fear of gaining weight.

These factors have determined the number of female smokers increasing exponentially over the last years; even more than the growth pace observed in men. Thus, pathologies such as lung cancer, beforehand considered almost exclusive to men, are nowadays as prevalent in women as in men. Just by mentioning that between 1951 and 1991 the prevalence of female lung cancer grew a 550%, there is very little to be added,(17) except that in the period of 20 years between 1980 and 2000, 3,000,000 of women have died early as a direct consequence of smoking.(18)

The same could be said about cervical cancer prevalence, in spite of all prevention campaigns carried out. Lack of fertility, early menopause, osteoporosis, and the harmful consequences over pregnancy, with an increase in the number of abortions, low weight at birth, prematurity and neonatal mortality, are immediate consequences of this epidemic increasingly growing in the female gender.(19,20,21,22,23)

Environmental tobacco smoke

Passive smoking is currently acknowledged as an agent damaging for the organism. (24,25,26,27)

If we stated that in our country 40% of people are active smokers, the remaining 60% is exposed to secondhand smoke and are passive smokers in a greater or lesser extent.

This severe problem is particularly sensitive in some spaces where there are high concentrations of people, and very especially in places such as Public Hospitals, which by definition should be protected from this plague, but where regrettably as we will see, smoking is still practiced and not in a negligible way.

The rights of nonsmokers are threatened by an element that endangers their health, and this is not limited to the mere discomfort from the nasty smell from cigarettes, which in itself is a right that is being breached, but also environmental pollution is a proven cause of disease.

Just as we stated and as it is possible to consult in an abundant bibliography,(28) the body, hair, skin, clothes, the house, the office, and the car are impregnated with a nasty smell, the heart rate increases, blood pressure increases, the risk of lung cancer, heart disease, and respiratory disease increases, as well as chronic bronchitis, frequent colds, asthma and emphysema, pregnant women have greater chances of having a kid with respiratory problems or difficulties to learn, the risk of sudden death syndrome is increased in infants, kids are more susceptible to coughing, sneezing, of being affected by asthma, bronchitis, middle ear infections, and suffering both colds and pneumonias.

The Environmental Protection Agency (EPA) from USA, has classified secondhand smoke as a Group A carcinogen, which means that there are enough proofs that it causes cancer in humans. The EPA has been using the Group A classification only for another 15 polluting substances, including asbestos, radon and benzene.

Likewise, as it is shown in a paper published in the issue corresponding to June 30th, 2004 in the prestigious British Medical Journal (BMJ), and that was conducted in 18 cities, the risk of passive smokers to contract a coronary disease or stroke is increased by 50 to 60%, and not just 25 or 30% as it had been reported previously.(29)

Secondhand tobacco smoke contains more than 4,000 chemical compounds. It is known or suspected that more than 40 of these compounds cause cancer. Moreover, many of these chemicals also appear in processed tobacco.

It is good to make a list of them, although reading it may seem awkward in a paper like this, just because if an environmental study was made at the core of a public space such as a Public Hospital, many of these harmful substances would be detected.

Para-aminohippurate (PAH) acid

Benz[a]anthracene

Benzo[b]fluoranthene

Benzo[j]fluoranthene

Benzo[k]fluoranthene

Benzo[a]pyrene

Chrysene

Dibenz[a,h]anthracene

Dibenzo[a,i]pyrene

Dibenzo[a,l]pyrene

Indeno[1,2,3-cd]pyrene

5-methylchrysene

N-nitrosamines

N-nitrosodimethylamine

N-nitrosoethyl methylamine

N-nitrosodiethylamine

N-nitropyrrolidine

N-nitrosodiethanolamine

N-nitrosonornicotine

4-methylnitrosamino-1-[3-pyridyl]-1-butanone

N-nitrosoanabasine

N-nitrosomorpholine

Aza-arenes

Chinoline

Dibenz[a,h]acridine

Dibenz[aj]acridine

7h-dibenzo[c,g]carbazole

Aromatic amines

2-toluidine-2

2-naphthylamine-2

4-aminobiphenyl-4

Different organic compounds

Benzene

Acrylonitrile

1,1-dimethylhydrazine

2-nitropropane

Ethyl carbamate

Vinyl chloride

Polonium-210

Inorganic compounds

Hydrazine

Arsenic

Nickel

Chrome

Cadmium

Lead

Aldehydes

Formaldehyde

Acetaldehyde

Crotonaldehyde

This environmental polluter, through these substances, causes 35,000 to 40,000 deaths by cardiac diseases in people who currently don't smoke in USA, near 3,000 deaths by lung cancer in nonsmoker adults, 150,000 to 300,000 infections in the lower respiratory tract (such as pneumonia and bronchitis) in children younger than 18 months, which results in 7,500 to 15,000 admittances for these reasons, in an increase in the number of cases and severity of asthma attacks in approximately 200,000 to a million children, and in an increase in the number of cases of otitis media in young children of smokers.

2. Description of the problem

Smoking in hospitals

In 1999, in the **First Virtual Congress of Cardiology** held on the Internet, the results were shown from a survey made during the second semester of 1997 by the Tobacco or Health Committee from the Department of Health in 15 hospitals depending from the

Department of Health of the Autonomous City of Buenos Aires. The hospitals were: C. G. Durand, C. Tobar García, B. A. Moyano, A. Zubizarreta, E. Tornú, D. Velez Sarsfield, R. Gutierrez, Santa Lucía, M. Curie, J. M. Penna, R. Mejía, C. A. Argerich, M. Ferrer, J. Garraham, and B. Rivadavia.

The results, after surveying 3,365 agents, showed a general prevalence of smoking of 35.1%. More than 15% of the analyzed staff stated they didn't know about the prohibition to smoke in hospitals. An 85.1% of the people surveyed manifested working with smokers. A thorough analysis of the sample showed that 30.3% of physicians, 34.6% of non-medical professionals, 36.3% of nurses, 45.5% of the management, and 35.5% of the rest of the staff smoked.(30)

A simple visit to these Hospitals let us know in plain view, that the problem thirteen years after the survey, still stands with the same or an even greater severity, to which we should add that back then and now, the patients that go searching for medical care, the people accompanying them, and other people that are occasionally in the buildings of care centers smoke; although it is worthy to stress that since the law 1799 was passed, this behavior has decreased notably in this population.

It may be inferred from this reference, that in our Hospitals the terrible paradox of the agent responsible of a greater demand for medical care, for being directly or indirectly responsible of the most prevalent pathology, is being consumed freely in corridors, offices, and in many medical offices and admittance wards, where patients precisely affected by those pathologies are cared for, predominantly in the evening and night.

Undoubtedly, about the severity of the problem, it is very worthy to take into account the study of environmental nicotine made in the Ramos Mejía Hospital, on October and November, 2002, which could surely be reproduced if performed in the other hospitals that make up the network of public hospitals:

		Nicotine concentration in microg/m^3	Total value adjusted by time
Hospital	Nursing office, traumatology room, women	1.33	1.33

Nursing office, traumatology room, men	1.94	1.94
Nursing office, ICU	5.04	5.04
Toilets of female patients, surgery, room 9	0.28	0.28
Toilets of male patients, surgery, room 9	1.05	1.05
Nursing office, surgery, room 9	1.32	1.32
Traumatology physicians room	0.37	2.48
Physicians room, ICU	5.07	5.07
Dining room for the staff (filter not analyzed)		
Cardiology physicians room	1.40	1.40
Men’s toilets, cardiology room	0.12	0.12
Coronary Unit office	3.18	3.18
Cardiology Room office	3.05	3.05
Office of the staff	0.75	1.33
Women’s toilets, cardiology room	0.10	0.10
Entrance hall	1.78	1.78
Office of the staff	2.14	3.78
Office of the staff	1.05	1.86
Coffee-bar in the Hospital	5.03	10.69
Coffee-bar in the Hospital	4.29	9.12
Obstetrics corridor	0.91	0.91
Traumatology men’s ward	0.19	0.19
Room for general physicians on call	4.27	4.27
Office for general nurses on call	0.64	0.64
Pre-OR – general staff on call	0.25	0.25

Conclusions: in the whole Hospital environment, considerable levels of nicotine were found. This included bathrooms of patients, sitting rooms for physicians and nurses, being markedly high in closed areas and the coffee-bar.

It is clear that regarding this addiction and its consequences, and the fact that the prevalence of smoking in hospitals is so high, the existence of forbidding laws, declarations of "smoke-free" areas, or the good intentions of the relevant authorities are not enough, thus being necessary to implement programs that have already proven to be efficient in other countries, with the goal of eradicating this affliction from the environment of public hospitals.

Smoking in physicians

Although, as it has been stated, the problem of smoking in the hospital environment is not the exclusive patrimony of physicians, we can say that it is their concern and responsibility to watch over Public Hospital to have a policy with the aim first, of helping active smokers to quit, and to become free from the danger caused by environmental pollution in their core to passive smokers.

Physicians should be leaders in the struggle against this disease, just as in the struggle against the rest of pathologies.

However, the problem has been dragging since the curricular education proper, since in our Universities there is no specific education that would prepare future medical professionals to struggle against tobacco addiction and the proportion of medicine students who are active smokers is very high, more than a third of them.(31,32)

According to a survey made by the Argentine Society of Cardiology in 18 institutions that covered 783 physicians, the prevalence of smoking was 28.6%.(33)

The prevalence is similar to other sources consulted that allow concluding that approximately a third of physicians are active smokers.(34)

For all that has been stated in the above analysis, it is necessary to provide our Hospitals with specific policies and tools aiming at effectively making them **tobacco-smoke-free areas**.

Why create a smoke-free Hospital?

The work place could be an important source of exposition to environmental tobacco smoke (ETS).(35)

The value of hospitals offering a coherent message to the population has been proven in the last systematic reviews on this issue. It has been proven that forbidding smoking in a hospital has greater benefits than duplicating the price of cigarettes.(36,37)

The other consideration is protecting others: patients, the staff, occasional visitors, from being exposed to ETS.(38)

Also, we have to consider the decrease of risk in fires and cleaning costs.(39)

Control should be done by appropriate policies based on preparation, follow up, and monitoring of results, with the commitment of all the different sectors of Hospital life. (40,41)

The benefits in the agents is indisputable, since besides nonsmokers not having to suffer ETS, smokers will decrease their consumption and a 3% will quit after 6 months.(42,43)

On the other hand, in patients the potential benefits will be remarkable, since smoking is an important risk factor of post-operative infection, admittance into the ICU, and in-hospital mortality.(44)

In brief, the hospital should be an area free of tobacco smoke.

For the hospital: Hospitals as structures have special features, besides their large physical dimensions there is a significant working population. They are also a place where patients with different pathologies stay, and at the same time they present an important flow of population that comes for a consultation or to accompany a patient. Health care institutions should hold a foreground position to prevent the smoking habit.

Since this is a community completely made up by health care workers, we assume that all its members, smokers and nonsmokers, to a greater or lesser detail, know that tobacco is harmful for health and that it increases the risk of acquiring some pathologies, many of which are treated in this environment.

A **smoke-free hospital** is an ambitious goal that entails compliance by all actors that are part of it, both the people that work and those who go there.

On the other hand, the hospital is no ordinary place. The behaviors observed in it acquire, more than in other places, the value of example in everything related to healthy living.

For the patient: Interrupting smoking is an integral part of prevention and management of diseases related to this habit. Being admitted into the hospital is a moment in which smokers are motivated to change their behavior. A smoke-free hospital is essential in providing care to the admitted smoker. On the other hand, environmental tobacco smoke (ETS) may worsen the symptoms of patients that suffer respiratory diseases.

For many people the decision to quit smoking is one of the most important steps to preserve their health and increase their life span.

For the staff: A nonsmoking policy in the hospital comprises raising awareness and the commitment of all the sanitary staff who hold an essential role and who are committed to put human resources to use to obtain hospitals with healthy environments. Likewise, the hospital workers should be protected against being exposed to secondhand smoke in any area of their work. Besides, we should consider that the presence of tobacco smoke in the work place is one of the reasons for the staff to relapse after having quitted. On the other hand, smoking is one of the main causes of fires in hospitals.

Improvement of quality of life and wellbeing of the Hospital population

Considering that work is being done with a limited universe of people –adults and young adults- some of which are already smoking, it should be attempted to restrict the areas were smoking is done, respecting the right to smoke of people, but also protecting the rights of nonsmokers to breath air free of nicotine and other polluters.

There are also reasons of the legal kind in the area of our Autonomous City of Buenos Aires, that provide grounds as to why the hospital should remain free of smoke:

- The General Associate Direction of Hospitals reminds of the validity of the terms of the Regulation 47,667 (BM 19816 and 19884), which states the obligation of strictly complying with the legal guidelines springing from the mentioned regulation, which states the following in the 1st and 2nd articles:

Article 1- “It is forbidden to smoke tobacco in any way within the offices or areas of the municipal sphere in which general public is attended. This includes both the staff and the public coming to them…”

Article 2- “Municipal employees in charge of the different areas of all institutions, will implement the necessary means to strictly comply with what is stated herewith.”

This Regulation 47,667 is enforced since 94/07/01 and it was regulated by Decree Nº 1,698/994 which in its 2nd Article states the placement of signs and the measurements and text and in its 3rd Article that it is understood by places devoted to attending the public that are only those in which taxpayers counter procedures are conducted and by common places connected to the areas of access from the public streets into the offices to attend taxpayers.

- The Regulation 47,668 (Municipal) rules since the same date and it states that:

Article 1- It is forbidden in the whole scope of the City of Buenos Aires, to provide, and/or sell cigarettes, smoke in any of its forms, and any other product of this nature that would encourage the vice of smoking, to minors under the age of sixteen (16) years old, whether for their own consumption or not, without exception.

Articles 2 and 3- are about penalties and fines.

Article 4-This Regulation should be obligatorily exhibited in all shops where tobacco is sold in any of its forms.

- Regulation 47,669 (Municipal) enforced since 94/07/14

It creates the Program of toxicological control of smoking. The statutory decree of the Regulation in its Article 2 – It creates the "Committee of Analytic Control of Tobacco" that will be constituted by two representatives of the Executive Department of the Municipality of the City of Buenos Aires; two representatives of the Honorable Deliberative Council of the City of Buenos Aires, and two representatives of the Chamber of the Industry of Tobacco.

At National level.

- Resolution 717/97 from 97/10/06 states: It is forbidden to smoke in the facilities and Institutions included in the National Program to Guarantee Medical Care Quality.

Article 1- It is forbidden to smoke in the facilities and institutions included in the National Program to Guarantee Medical Care Quality, whether in technical sectors – professionals such as those belonging to the management and general services, regardless of whether they are directly related to the patient or not.

Article 2 – Join the guideline that is approved by the present resolution to the National Program to Guarantee Medical Care Quality, being of obligatory compliance for all those jurisdictions, institutions, and/or organizations that adhere to such Program.

Resolution 348/2003 from 2003/05/21 states: The guidelines of Organization and functioning of the Maternity Services should be approved, and added to National Program to Guarantee Medical Care Quality.
(According to this National resolution and since Maternity Services have joined the Program to Guarantee Medical Care Quality, smoking is banned in any place in any maternity service.)

Municipal Hospitals requested becoming members of the National Program to Guarantee Medical Care Quality.

- In Geneva, 192 countries members of the WHO met and signed a historical agreement: the Framework Convention on Tobacco Control, the first international treaty about public health approved under the sponsorship of the WHO. In the month of September, 2003, the President of this country back then signed the Convention on Tobacco Control. Regrettably, the lack of validation by the Parliament for the abovementioned Convention, for reasons it would be good to be explained for the democratic health of a country, have determined that ours is one of the few countries that in fact, have not adhered to the Framework Convention.

Breathing in environments free of tobacco smoke **is a constitutional right**, according to what is analyzed by Dr. Felix Lonigro, Professor of Constitutional Right of the University of Buenos Aires.

Annex 2

This paper attempts to outline the elements that could be the grounds for such policies and tools. It will be based on the European Guidelines for Smoke-Free Hospital, prepared by the European Network for Smoke-free Hospitals and in the project that is in

the full stage of implementation, prepared and directed by the members of the Tobacco or Health Committee of the General Hospital of Acute Diseases, Dr. Ramos Mejía.

3. Objectives

a-Purpose: Achieving a smoke-free hospital in the middle term. A three-year term was established.

b-General objective: To remove the environmental tobacco smoke in shared spaces in the Hospitals of the sphere of the Government of the City of Buenos Aires.

c-Specific objectives:

a) Constitute a work team to promote healthy habits.

b) Determine scientifically the prevalence of tobacco consumption in patients and the staff of the Hospital.

c) Implement specific activities devoted to education to achieve areas free of tobacco.

d) Consolidating the professional team devoted to the treatment of smokers.

e) Facilitating the access of patients and staff to treatment for smoking.

f) Encouraging the development and progressive application of anti-tobacco restrictive legislation.

4. Plan of action

Activity 1

1a. **Constituting an intersectorial and multidisciplinary work team.**

The team will be made up by people identified with the topic, made up by representatives of the whole health care team. It is important to have the participation of representatives from each of the professions acting in the Hospital.

1b. **Methodology of action**

The significance of this project in the framework of health care quality in hospitals and quality of life for each of the members of the hospital community will be emphasized.

1c. **Actions**

- Discussion and construction of a shared work project.
- Construction and evaluation of a survey to determine the prevalence of smoking in patients and the staff of the hospital.

- Contact with the hospital population.
    - Dissemination of the project.
    - Implementation of educational campaigns with selected targets.
        - Signs in the hospital.

Specifically oriented training.

<u>Activity 2</u>

A-Scientific determination of the prevalence of smoking

A self-administered survey will be made in patients and the staff of the hospital to determine prevalence and main characteristics of consumption in shared spaces.

Sample: to be determined in each hospital according to the total number of members of the staff.

Target: random sample.

Date to perform it: to be determined in each hospital.

Date to repeat it: two years later.

Questionnaire

ANNEX 1

B-Design of activities devoted to education to achieve spaces free of smoke.

Dissemination of the project:

-Call to the press committee of the hospital.

-Call to the media.

-Design and application of signs:

- Definition of spaces for smokers away from the spaces where the public is attended and the admittance areas.
- Placing signs with information in strategic places.
- Placing ashtrays at the entrance of the hospital.
- Identification of voluntary staff (with pins, bracelets, or similar items)

-Construction of a newsletter and signs with dissemination material.

- Topics: reasons why quitting smoking is so hard, characteristics of addiction to cigarettes, laws and regulations that protect nonsmokers, characteristics of secondhand smoking.

-Conduct informative meetings for the staff of the hospital.

- CATA (Technico-Administrative Advisory Council by its Spanish acronym)
- Chiefs of service
- Nursing supervisors
- Secretaries
- Representatives from companies under contract
- Chiefs and instructors of residents
- Representatives from universities

-Conducting meetings with patients and their relatives.

Activity 3

Specific training and education

-Course on training leaders

-A course to train leaders in promotion of health will be implemented. All the actors of the hospital may participate in it if they wish so. People capable of acting in the dissemination and evaluation of the project will be selected in the courses.

-Training of security and information desk staff.

- Information on the program
- Information on spaces assigned to smokers and nonsmokers
- Role in the regulation of smoking
- Techniques to approach people who smoke in spaces where it is forbidden.

Activity 4

Expanding the program "I NO LONGER SMOKE"

Professionals that wish to join the group will be called and trained.

Call to professionals

- Professions included: all that wish to participate.
- Times and days to provide attention: the times and days will be expanded.

Unlimited access to treatment

- More appointments
- Motivation for the treatment of the addiction for the staff of the hospital
- Agreements with other health care services.

<u>Activity 5</u>

Design and encouragement to the progressive application of restrictive anti-tobacco legislation

Design of legislation

- Preparation of a Resolution of Directors of Hospitals and Councils of Administration for tobacco-free spaces.
- Approval and support from Hospital Unions.
- Appointment of a relevant authority of application of the sanctions that may correspond.
- Provision of support of the legislation from the Nation, the City of Buenos Aires and the Ministry of Health.

Application of guidelines

- Notification to all chiefs of Areas.
- Notification to the staff, patients, and relatives.
- Specific instructions for the security staff of the Hospital.

5. Schedule of work

5.1. Setting up of a work team and design of the survey: six months since the approval of this project.

5.2. Study of prevalence in the staff of Hospitals (implementation of the survey): to be determined in each center. Repetition after two years.

5.3. Study of prevalence of tobacco-dependent diseases in patients admitted to be determined in each Hospital.

5.4. Training course for leaders.

5.5. Conducting informative meetings for the staff of the hospital.

5.5.1 CATA

5.5.2. Chiefs of Service

5.5.3. Nursing supervisors.

5.5.4. Secretaries.

5.5.5. Representatives from hired companies.

5.5.6. Chiefs and instructors of residents.

5.5.7. Representatives from universities.

5.6. Dissemination tasks

5.6.1. Scheduled speeches in all Hospital facilities.

5.6.2. Brief course for voluntaries that will go through Hospitals inviting not to smoke.

5.6.2.1. Implementation of the step from the approval of the project.

5.6.3. Permanent campaign of specific signs and posters.

5.6.4. Monthly newsletter.

5.7. Determination of places where smoking won't be allowed and regulation.

5.7.1. Places.

5.7.2. Regulation.

5.8. Proposal of management to quit smoking to all the members of the staff that wish so.

5.9. Conducting the self-audit survey. ANNEX 3

5.10. Study of legislation appropriate for the Hospital.

6. Budget

The kickoff of the project makes it necessary to assign a budget item for the dissemination campaign, printing signs and posters, identification bracelets and/or pins for volunteers, didactic material, drugs for the treatment to quit smoking for the staff.

Conclusions

As a conclusion, just passing the law 1799/05 has not made the Hospitals depending from the Ministry of Health of the Autonomous Government of the City of Buenos Aires, places effectively free of tobacco smoke.

Such priority goal would be feasible, according to the international experience on this issue, making converge what the law establishes with a specific plan to be implemented in each hospital, the aspects of which are developed in this document, and by the existence of Quitting Offices that would provide counseling and treatment, to the staff and to the general public that so requests it.

ANNEX 1 **Survey**

Age – gender – function Service

1. Have you ever tried smoking in your life, even one or two puffs?

☐ YES

☐ NO

2. Have you smoked at least 5 packages of 20 cigarettes (100 cigarettes), 20 cigars, or 20 pipes in all your life?

☐ YES

☐ NO

3. Have you smoked at any time in your life, every day, for at least 6 months?

☐ YES

☐ NO

4. How many units, in average, do you or did you smoke per day?

----- cigarettes / day

----- pipes / day

----- cigars / day

5. For how many years did you smoke on a daily basis?

----- years

6. Currently:

☐ You smoke daily (at least 1 cigarette per day)

☐ You smoke occasionally (not daily)

☐ You don’t smoke

7. If you currently do not smoke on a daily basis, when did you quit?

☐ Less than a month

☐ 1 month or more but less than 6 months

☐ 6 months or more but less than a year

☐ 1 year or more but less than 5 years

☐ 5 years or more but less than 10

☐ 10 years or more

8. Did you ever quit smoking for a term of 1 year or more?

☐ YES

☐ NO

9. What do you plan to do in the next five years with your tobacco consumption?

☐ I will continue smoking daily

☐ I may continue smoking

☐ I may not smoke on a daily basis

☐ I will smoke occasionally

☐ I will not smoke

10. In your opinion, the exposition to environmental smoke or smoking passively, is harmful for your health?

☐ YES

☐ NO

11. Should smoking be banned in closed public places such as restaurants, bars, or schools?

☐ I completely agree

☐ I agree

☐ No opinion

☐ I disagree

☐ I completely disagree

12. Should smoking be banned in all areas of hospitals and places related to health care?

☐ I completely agree

☐ I agree

☐ No opinion

☐ I disagree

☐ I completely disagree

13. Do you wish to receive specific information related to tobacco control and use?

☐ YES

☐ NO

14. What of the following options better describes the restriction guidelines for smoking in public places (such as toilets, waiting rooms, and dining areas) of the institutions where YOU develop your activities?

☐ It is forbidden to smoke in all public places

☐ It is allowed in some public places

☐ It is allowed in all public places

☐ You don't know

15. Which of the following options better describes the guidelines that restrict smoking in the areas devoted to attend patients (medical office, admittance ward, therapy ward)?

☐ It is forbidden in all places

☐ It is allowed in some places

☐ It is allowed in all work places

☐ You don't know

16. Would you agree with a smoke-free hospital?

☐ YES ☐ NO

<u>Annex 2:</u> The right to breath air without ETS is a constitutional right

Smoking is also a legal problem

http://www.lanacion.com.ar/03/09/05/do_524785.asp

by Félix V. Lonigro

for LA NACIÓN

The goal of this article is not to highlight what is evident: that cigarettes kill a human being every eight minutes, that 40,000 people die yearly because of diseases produced by cigarettes, that a third part of minors younger than fifteen years old smoked at some

time by the time they reach such age and have incorporated the vice, that smoking is a plague that afflicts a forty percent of Argentine people.

After all, it is true that smokers know what the risk is when they decide to consume cigarettes. It is sad to see how they harm themselves not finding a solution to such cruel self-ill-treatment, but everyone is free to do what is most satisfying to them.

However, cigarettes do not stop at eroding the health of the person who has the vice of smoking, but it also advances on the rest of people, on those of us who wish to take care of our health and breathe clean air. It is true that nobody is deprived from doing what regulations don't forbid; it is openly stated in our national Constitution, in article 19. But exercising our rights is not completely free, because the limit is where the rights of others begin.

If everyone were to exercise their rights without limitation, without taking into account whether they are offending morality, good forms, or if they are harming others, we would be facing what is called "abuse of right" and, according to the Civil Code, the law does not abet the abusive exercise of rights.

People who smoke may exercise their rights to do it as long as they are not harming others. Otherwise, the right to smoke becomes abusive. But as it has been thoroughly proven that the smoke that emanates from cigarettes does not just harm the smoker, but also the person breathing that smoke, the conclusion is that when a smoker exercises the right to smoke at the same time and environment that someone else attempting to exercise his/her right not to do it, the right of the smoker becomes abusive. Therefore, it is the smoker who should stop exercising their right.

There is a right with which we are all conceived: the right to physical integrity, also called the right to health. This is acknowledged as an "implicit right" by the national Constitution, and also expressly by the Pact of San José de Costa Rica, which has constitutional hierarchy for Argentine people.

Moreover, since 1994 the Constitution considers for the general community, the right to live in a healthy and balanced environment. It is a collective right that every citizen has in a shared way with others. No community can live in a healthy environment if the air is polluted with poisonous chemical elements contained, for instance, in the smoke that emanates from cigarettes.

Thanks to all the rights the Constitution grants us, implicit or expressly, inhabitants have a right to have our health preserved. Any nonsmoker has the right to demand that no one should smoke in small, closed, or semi-closed spaces. In this sense, our leaders –their goal being leading the fate of the Nation and satisfying the needs of those being led and always seeking a common good- should take all the necessary steps to prevent a large part, although a minority, of the population (those who smoke) from damaging or causing harm to the majority, who do not have this habit.

Luckily, in the light of the article by the current Ministry of Health, Dr. Ginés González García, published a few days ago in LA NACIÓN, it seems that the need to act on this delicate issue has been understood. National legislators and those from the different provinces should still intervene and pass the necessary laws to protect the rights of nonsmoking workers in work environments, and those of consumers and nonsmoking users in restaurants, pubs, and different places with public access.

Smoking is a problem for the health of smokers, but also for the health of those who do not smoke. Starting from this truth, another reality is born: the cigarette is also a legal problem. For this reason authorities cannot or should not remain passive before the consequences generated by the vice of smoking: not just because they should protect the health of those being governed, but also because they should avoid the endless conflicts that in all fields of coexistence may arise between smokers and nonsmokers.

The author is a Professor of Constitutional Right in the National University of Buenos Aires

ANNEX 3

Quick auto-audit questionnaire to evaluate the performance to achieve smoke-free hospitals

1. Attract decision makers	0	1	2	3	4	N / A	Notes
1.1 The hospital documents (general contracts, public documents, etc.) specify the policy of the hospital for a tobacco-free environment							
1.2 The staff and patients are clearly informed about anti-tobacco policies							

2. Appoint an action group	0	1	2	3	4	N / A	
2.1 A Committee is appointed for coordinated management about smoking in the hospital							
2.2 The leader belongs to the high management level							
2.3 A new proposal or strategy was designed the previous year							
2.4 The prior actions and strategies were evaluated the previous year							
2.5 The result of such evaluation is evaluated: was the action achieved in the scheduled time, it was not achieved, or it was partially achieved?							

3. Design a training plan	0	1	2	3	4	N / A	
3.1 A training program is designed for the hospital, about the way to talk to smokers							
3.2 Time is given to the staff during working hours to attend the training program							

4. Organize activities to quit smoking	0	1	2	3	4	N / A	
4.1 Informative material is designed, as well as a program to quit smoking in the hospital							
Leaflets and didactic material are available for the staff, patients, and visitors							
Individualized counseling available for the staff and patients							
Group counseling available for the staff and patients							
Nicotine replacement therapy/pharmacological therapy available							
Alternative/supplementary therapies available							
4.2 There is a coordinator appointed for the activities to quit smoking							
4.3 The program is free of charge for the staff							

4.4 Time is given to the staff during working hours to attend the training program							
4.5 The program makes a follow up of clients							
4.6 The drop-out rates for the habit are established yearly for the staff and visitors?							

5. Indicate areas for smokers	0	1	2	3	4	N / A	
5.1 It is forbidden to smoke in all meals, the work, and common areas used by the staff, the patients and visitors							
5.2 The areas appointed for smokers are completely separated from the areas for nonsmokers and away from the physical working area							
5.3 Appropriate ventilation and air extraction							

6. Adopt appropriate indications	0	1	2	3	4	N / A	
6.1 In all the areas for the staff, visitors, and patients, there are clear indications that explain the policy for an environment free of tobacco, and indicate the areas free of tobacco.							

7. Remove all incentives	0	1	2	3	4	N / A	
7.1 There are ashtrays only in the areas appointed for smoking							
7.2 No cigarettes are sold within the building of the hospital							

8. Renew and enhance information	0	1	2	3	4	N / A	
8.1 There is at least a two-year plan of action to renew information and training in the hospital							
8.2 There are continuing programs of education for the staff and patients							

9. Ensure follow up	0	1	2	3	4	N / A	
9.1 The policy is monitored and reviewed yearly							
9.2 The responsibility of monitoring is of the committee							
9.3 The monitoring process includes complying with the policy and communication systems							
Total (maximal: 124)							

References: 0 = it was not implemented; 1 = some aspects were implemented partially; 2 = more than half was implemented; 3 = almost implemented; 4 = totally implemented. N/A = not applicable.

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