**Academic medical centers should not exclude smokers from employment**

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**Abstract**

 Many health care institutions, including academic medical centers, have adopted policies excluding smokers from employment.  Claims advanced on behalf of these polices include financial savings from reduced health costs and absenteeism as well as the benefit of a message of healthy living conveyed to local communities. We suggest that the institutional savings from these policies are speculative and unproven. Because smoking is more prevalent among the poor and because most quit attempts fail, the loss of employment opportunities following smoker bans bodes ill for local communities that are not affluent.

 While private businesses may rightly choose not to hire smokers in the 19 states where such policies are legal, academic medical centers should consider similar action in light of the values they profess. The traditional values of medicine include service to all persons in need, even when illness results from addiction or unsafe behavior. Secular academic communities require a shared dedication to discovery without strict conformity of private behavior or belief. The authors conclude that institutional policies of hiring smokers and helping them to quit are both prudent and expressive of the norms academic health professionals seek to honor.

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On November 15, 2012, the health institutions of the University of Alabama at Birmingham (UAB) School of Medicine became the first state academic medical complex in the United States to ban the hiring of smokers among new employees. Effective this past summer, candidates for employment are tested for nicotine. Those testing positive for nicotine will not be hired, save for those instances where it can be determined through additional testing that tobacco cessation therapy accounts for an initial positive test. In declining to hire employees who smoke, UAB joins a growing number of health care institutions, such as the Cleveland Clinic, Geisinger Health System, and the University of Pennsylvania.

 In what follows, we take note of the competing ethical and policy claims regarding employee smoking bans and we argue that adjudication of these claims (favorably or not) does not provide a sufficient ground for decisions about employee smoker bans in academic medical centers. We review arguments commonly made in support of employee smoker bans and suggest that these arguments are, at best, inconclusive. Most employers could, however, legitimately choose to enact such bans, as a matter of law and perceived organizational advantage. We suggest that academic medical leaders are not in the position of most employers. Leaders of academic medical centers ought to choose policy based not only on impersonal policy considerations but also on the unique character of the practices they serve: most notably, medicine and scholarship. We suggest that the normative standards of these practices are incompatible with employee smoker bans.

**The employee smoker ban debate: arguments for**

 Typical rationales offered for smoker-free workplaces generally stress both their anticipated consequences and their expressive function. Businesses are said to gain financial benefit by not hiring smokers, who are less productive and who incur higher health care costs than non-smokers.1 Such policies also “send a message” about smoking to the larger community.

 Institutions excluding smokers among new hires have not generally extended such exclusion to existing employees. While differing stances toward new and existing employees opens employers to charges of inconsistency, it also avoids the upheaval that would likely accompany a demand that existing employees quit smoking or be terminated. Proponents of smoker bans would likely argue that compromise with existing employees is necessary to achieve the longer term goal of a smoker-free workplace. And they would likely favor other measures calculated to achieve smoking cessation in current employees, such as wellness programs involving financial or other penalties for employees failing to participate or meet wellness targets.2

 The financial impact of a smoker ban on employers in the form of lower health care costs may be considerable. Berman and Crane offer the figure of $2056 in excess health costs per employee per year, and $5088 in total yearly excess costs.1 Health care institutions in the current wave of employers instituting smoker bans are not, however, emphasizing cost savings as the most important rationale for them. In public statements more weight is typically placed on the expressive function of these bans. As a spokesman for the Cleveland Clinic puts it: “as a health care institution, whose inherent mission is healing the sick and cultivating a healthier community, does it make sense to support a habit that leads to disease, disability and death?”3

 Proponents of smoker bans emphasize their societal impact even more than their advantages for individual institutions. Such bans, it is asserted, will eventually contribute to a lower prevalence of smoking in society with accompanying benefits. One such benefit is lower societal health care costs. The society-wide financial impact of lower smoking prevalence is actually unclear, however. Health care costs diminish in early years after smoking cessation but increase as the former smoker lives longer. Barendregt suggested that with no discounting, smoking cessation lowered societal health care costs up to 26 years of follow up but that the beneficial effect on costs reversed if follow up was longer. The break even point at 26 years is extended to 32-35 years with the use of conventional discount rates.­­4 It is unclear that a financial analysis of decreased smoking prevalence should be limited to health care costs, however. Diminished collections of cigarette taxes is a cost to society of smoking cessation which must figure in striking a society-level balance sheet as to the effects of smoking cessation. Of course if one’s focus is population health rather than costs, the benefits of smoking cessation are clearer. Even if financial costs are higher, these costs are a relatively efficient means to diminished prevalence of fatal disease and, hence, worth incurring.5

 Smoker bans are more coercive than traditional smoking bans as they control behavior outside of the workplace. The case for the additional coercion in smoker bans is twofold; first, proponents of employer smoker bans join proponents of more traditional smoking bans in pointing to harms inflicted by smokers on others as a reason for coercive anti-smoking measures. Of course the spillover effects of smoking on non-smokers are more difficult to invoke as a reason for smoker bans than for smoking bans—as the latter are sufficient to prevent exposure to second hand smoke. But increasing concern about “third hand smoke”—the residue of nicotine and other toxins on the hair and clothing of smokers that persists after smoke has cleared—offer a similar rationale for smoker bans.6 Secondly, proponents of smoker bans contend that the putative benefit of more smokers quitting is worth the price of the additional coercion involved in smoker bans. Smoker ban proponents thus exemplify an increasing tendency in the public health community to dispense with any requirement for spillover effects before engaging in coercion. Public health policy makers have recently begun to heed calls for a low threshold for embracing “hard paternalism”—that is, coercive interference with purely self-regarding harm as a means to the improved welfare of those coerced .7 And smoker bans are one example of such coercion.

 The final element in the case for employer smoker bans is an appeal to the desirability of further “denormalizing” smoking in society. And, as above mentioned, in the case of health care institutions there is an accompanying claim that excluding smokers from employment furthers institutional coherence.

**The employee smoker ban debate: arguments against**

 Opponents of employee smoker bans dispute both the welfarist claims on behalf of such bans and the ethical case for subjecting smokers to hard paternalism. The claims for institutional health care costs related to employees who smoke are open to question. Berman and Crane’s source analysis for their estimate is unpublished, and their published estimate for the costs of a smoking employee ($5816 per year, including absenteeism presenteeism, and smoking breaks) applies hourly compensation estimates ($26.49/hour), exceeding compensation for positions most typically held by smokers at medical centers. The lion’s share of Berman and Crane’s estimated financial loss ($3077) embeds an assumption that every smoker takes 2 unsanctioned smoking breaks of 15 minutes apiece (30 minutes/day). Whether licensed practical nurses or janitorial staff take such breaks or proportionately reduce the number of patients cared for or buildings cleaned is unstudied. Empirical research shows that smokers outside office buildings consume a cigarette in 3.9 minutes.8 Finally a significant component is based on estimates of unproductive work hours (presenteeism), a survey-derived measure that did not meet its developers’ criteria for predictive validity.9 In short, while employer cost calculations may help to justify efforts to assist employees who smoke, they do not readily justify categorical denial of employment to persons who smoke at home.

 The claims for societal benefits from smoker bans are even more questionable than those of institutional benefit. Most importantly, the likelihood of smoker bans having a causal influence on smoking prevalence is low. A Cochrane Review of comprehensive and partial legislative smoking bans did not find that they reduced the overall prevalence of smoking.10 If legislative bans do not reduce population-level active smoking, it seems excessively hopeful to presume that employee bans will do so.

 In contrast to the likely lack of efficacy in diminishing smoking prevalence, employer smoker bans may be anticipated to cause tangible harms to the communities in which employers instituting such bans are located, particularly if the employers in question employ a high proportion of a community’s working citizens. Smokers are only 18% of the adult population but 26.1% of those with income less than $35,000/year and 25.5% of those without a high school diploma.11 Health care workers reflect a similar pattern: smoking is uncommon among physicians and pharmacists, but moderately prevalent in most other health care occupations, especially service staff and licensed practical nurses (Figure).12,13 In many urban settings where large medical schools operate, it is likely to be poorer African-Americans who will lose the opportunity to work at a dominant employer that offers health insurance, long-term advancement and retirement benefits. In response to the incentives created by “no-smoker” hiring policies, some will in fact quit smoking. But with success following fewer than 5% of quit attempts,14 most will not. At the community level, the welfare effects of employee smoker bans are more likely to be harm than benefit.

 Opponents also question the legitimacy of the hard paternalism involved in employee smoker bans. Employers, the argument goes, ought not to reach into the private lives of employees when private activities do not affect workplace performance.15 If employee smoker bans are acceptable, what is to restrain employers from prohibiting other employee behaviors similarly risky—such as overeating, bad driving, or sexual promiscuity? External constraints on self-regarding activities are perhaps justifiable when the gains are great and the costs are low—as in the case of seat belt or motorcycle helmet laws. When the costs are high, as they are to smokers who either wish to continue smoking or cannot quit, such constraints should be avoided.16

 How one adjudicates the policy and ethical debates over smoker bans will depend on the answers given to questions very much open in contemporary discussion: how does one weigh the relative importance of the welfare vs. the unconstrained agency of smokers? What constitutes autonomy and how far is it legitimate to coerce those making self-harming decisions that are imperfectly autonomous? How bad is smoking compared to other risky behaviors and how does one weigh the cost to smokers of denied employment against the putative gain of less societal or community future smoking? These and other such difficult judgments will condition one’s ethical conclusions regarding employee smoker bans. We do not propose to attempt a resolution of the ethical issues. It seems to us that at the very least, institutional smoking bans are ethically permissible (in general), even if some think them to be ethically objectionable. The legal regime in states without anti-smoker discrimination laws clearly permits smoker bans by employers. Our preference for freedom of association suggests that most employers should hire as they please within the constraints of applicable law.

**The relevance of institutional character to institutional conduct**

 The debate over smoker bans has a dimension for health care institutions that is absent in the wider societal context. While it is one thing for businesses to ban the hiring of smokers, it is another for health care institutions to do so in the name of health. Such an anti-smoker hiring stance implies a position on both the content of the professional norms of medicine and on how far those norms may properly govern health care institutional activities only indirectly related to the provision of health care, such as the hiring of nurses, doctors, janitors or clerks.

 The positions taken on these two issues must be a matter of judgment rather than demonstration. We shall argue that it is indeed fair to extend the norms of medicine to a hospital’s hiring practices; but that proponents of smoking bans have mistaken what the norms of medicine demand as to whom hospitals should hire. Our argument will be decisive only for those who are both sufficiently part of the medical community to be governed by its norms and also who recognize our explication of those norms as resonant with their own understandings of who they are as health care professionals. We thus proceed by appealing to presumptions about practical ends that we take our opponents to share—that is, an adherence to medical norms and a sense of what these are and how they bear in professional life. Such an appeal is an inevitable feature of ethical argument, which must at some level be a seeking of common ground with one’s opponents.17

 While it is an open question how far professional norms should extend in determining the conduct of institutional activities subsidiary to professional work, proponents of anti-smoker hiring policies for health care institutions clearly connect these policies to the health care institutional mission. They presume rather than argue for the importance of this connection, asserting the congruence of smoker bans with the health care institutional mission as an important virtue of these bans. We shall take them at their word, agreeing that institutional norms can and should insinuate themselves into institutional activities subsidiary to the institution’s primary task—at least for some such activities in the case of health care institutions. The question at issue then becomes what medical norms demand as regards the hiring practices of hospitals and other institutions which are defined by the work of medical professionals.

 We suggest that smoker ban proponents have mistaken the professional norms that they claim to be honoring with bans on hiring smokers. Health care workers are expected to foster healthy behaviors through respectful alliance with the patients they wish to help, a posture articulated in the study of motivational interviewing.18 But “health” does not stand above “care” among the norms of medical practice; in fact, the latter is more important. Health care workers exemplify an ethic of care, including care for those whose ill health might be their own doing. While there may be a case for having patients “take responsibility” for their health at the level of insurance purchase, we do not consider individual responsibility for illness as disqualifying patients for care. Nor should we. This stance, separating individual bad choices from our response to individual need, is utterly at odds with employee smoker bans, which assimilate the moral status of the activity to the actor and label both as unwelcome. These bans reflect a moralization of health, characteristic of late 20th century middle and upper class life, in which virtuous health behaviors serve as a marker for a “secular state of grace.”19 Whatever the merits of this moralization, its manifestation in smoker bans seems incompatible with mercy, charity, and even social justice in so far as such bans diminish the employment prospects of the poor.

 As health care professionals we stand for health; but our more important priority of care suggests that while the message we ought to be sending to smokers need not be approval, it ought to be one of compassion, inclusion and, as Dr. Albert Schweitzer put it, “fellowship.” If allowing smokers to work in an institution conveys institutional support to smoking, how does allowing smokers to be cared for in the same institution not similarly convey such support? Employee smoking ban advocates who presume that the divide between hiring and banning smokers tracks a divide between expressing support and disapproval of smoking are denying the possibility of making a distinction that physicians not only commonly make but must make if they are to be true to their profession: between the patients whom we are charged to care for and the multifarious unhealthy habits, activities, decisions, and propensities that contributed to their illness. Support of the one need never be tantamount to support of the other. Medical norms enjoin us to take care of the sick—not the deserving sick, the virtuous sick, or the well-behaved sick—merely the sick. The messages we send in our hiring as in our other institutional practices should be affirmation of all prospective patients, an affirmation that need not be construed as approval of their unhealthy activities. In the case of smokers, health care institutions ought to hire them freely and then encourage them to quit smoking. The message actually conveyed by an employee smoker ban to smokers is unlikely to be one of an affirmation of health; it is far more likely to be received as a personal affront or rejection. Such a message is incompatible with who we are as physicians and health care professionals.

 We believe that an institutional identity allied to the profession of medicine should be sufficient to rule out employee smoker bans for such institutions. But what of the other aspects of institutional identity assumed by academic medical centers? What, in particular, does an *academic* identity imply as to hiring practices? While the distinguishing character of academic inquiry is generally taken to be the search for knowledge, academic institutions have often sought to cultivate distinctive forms of community. Prohibitions on smoking or other forms of unhealthy behavior seem neither more nor less anomalous as conditions for membership in a given academic community than the restrictions often placed on students or faculty by religious, military, or other academic institutions distinguished by the special form of community they seek to cultivate. Of course the case is different for academic institutions eschewing a particular sectarian, cultural or other communal identification. While nonsectarian public and private universities often endorse various social and political ends as goods, they generally make a point of avoiding the requirement of behaviors or beliefs related to such ends among students or employees. Members of nonsectarian academic communities are expected to conform to the law and to standards of behavior that allow academic inquiry to proceed. They are not to be otherwise required to adhere to standards of belief or behavior derived from particular visions of the good, even visions valorizing the cultivation of health. As secular academic institutions uncommitted to exclusive forms of community, our hiring practices should reflect academic values, which suggest the inclusion of all who can participate in the academic enterprise—including smokers.

 If our argument concerning smoker bans and the norms of medicine and academia is correct, smoker bans will not further align hospitals with the health care professions; and they will not align academic hospitals with the norms of the university. They will instead alienate the health care professionals working within hospital walls. That we have come to such a pass is in part a function of the recent evolution of hospitals. As the era of professional dominance in hospitals has receded, hospitals have increasingly become aggregates of loosely coupled subunits, among which are multiple vigorously contending “institutional logics”—most notably the professional and the managerial.20

 While there is no reason to suppose that managerial values (e.g. efficiency, entrepreneurship, cost-containment or marketing) are intrinsically antithetical to professional norms, the two perspectives clearly offer the potential for conflict. As an operational matter, bans on hiring smokers have issued from the managerial side of hospital leadership, naturally enough, as these bans fall under the purview of personnel management. The obvious managerial priority served by these bans is cost-containment. Those issuing the bans have implicitly recognized the inadequacy of that rationale for them in appealing to the norms of health care for additional support. As we argue, the appeal misfires and these bans will not have the anticipated effect of inducing professional solidarity with the hospitals instituting them.

 Physicians and other health care providers working in hospitals presently feel besieged by requirements imposed by hospital management—by the deluge of bureaucratic work imposed upon them by electronic health records and order entry; by performance measures that seem either unrelated to quality care or likely to subvert such care; and by sudden bureaucratic imperatives to address the management goal of the moment by, seemingly, any means necessary. Bans on hiring smokers will not, of course, directly affect most physicians. But they will be perceived as one more sign that hospital management is out of touch with what is important for any institution that claims to exemplify the norms of medicine. Hospitals, including academic hospitals, should welcome all potential employees committed to caring for the sick; and they should seamlessly extend their posture of caring for patients to employees who engage in unhealthy practices, including smoking.

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