LETTERS

SMOKING AND TOBACCO USE WITHIN THE DEPARTMENT OF VETERANS AFFAIRS

Offen et al. provide an insightful review of the complexity of enacting tobacco control policy at the federal level, as seen in their case study of the efforts by the US Department of Veterans Affairs (VA) to adopt a smoking ban in VA medical facilities in the early 1990s.[1]

As the authors indicated, tobacco use among the US military has traditionally been higher than among the civilian population.[1] In recent years, however, the VA has made great strides in reducing the rate of smoking among veterans served. For veterans enrolled in the VA health care system in 2011, the proportion of smokers was 19.7%,[2] comparable to the 19.0% reported for the United States as a whole in 2011.[3]

Although federal law still requires that VA health care facilities provide areas where patients can smoke,[1] progress has been made in reducing exposure to secondhand smoke for both veterans and VA employees. In citing a 2005 VA survey on smoking and tobacco use cessation within the VA, the authors incorrectly stated that one quarter of 783 smoking sites reported by VA facilities were indoors.[1] In fact, all 783 smoking sites were outdoor smoking areas or shelters.[4] The 2005 survey actually reported that 36 out of 158 VA facilities (23%) still had an indoor smoking area somewhere at the facility, mainly in nursing homes and inpatient psychiatric units.[4] Although still far from ideal, by 2009 this number had dropped to 19 facilities; 88% had complete indoor smoke-free policies in place.[5]

In referring to military and veteran facilities, it is important to note that the Department of Defense (DoD) and the VA are distinct federal executive branch agencies. Their various policies and initiatives are independent of each other, reflecting the differences in their populations and missions. Thus, in describing the VA tobacco control efforts as a pattern of "advance and retreat," the authors incorrectly attribute DoD policies and initiatives to the VA.[1,6] The article they cited discusses DoD initiatives only, not the VA or VA policies.[6] This misperception that the two departments operate as a single unit is not uncommon, but it is one that must be avoided in future studies. ■

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This letter was accepted April 3, 2013.
doi:10.2105/AJPH.2013.301375

***Note**. The authors certify that there is no financial conflict of interest with any financial organization with interest in the subject matter discussed in the letter. The views expressed here represent those of the authors and not necessarily those of the US Department of Veterans Affairs.*

Contributors

K. Hamlett-Berry and D. E. Christofferson drafted the letter. R. A. Martinello supervised the overall writing and edited the final version.

Acknowledgments

The authors thank Richard Kaslow, MD, for his insightful comments.

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OFFEN ET AL. RESPOND

We appreciate the comments by Hamlett-Berry et al. We apparently created confusion based on a misreading of the following paragraph from the Institute of Medicine report,[1] which discusses both smoking shelters and smoking areas:

> According to the 2005 Smoking and Tobacco Use Cessation Report on tobacco-use practices at 158 VA hospital facilities (VA, 2006b), 51 VA facilities provide 134 smoking shelters for patients only, 41 facilities provide 76 shelters for employees only, and 137 facilities provide 573 shelters for use by both patients and employees, with some facilities providing up to 32 shelters for combined use by patients and employees. Almost all (91%) of the VHA facilities indicated that patients and employees smoke in the same designated smoking areas. Of the 158 facilities surveyed, 77% are smoke-free indoors; 23% (36) permit some indoor smoking in areas such as long-term-care inpatient, locked psychiatry wards, resident rooms, and nursing-home units; and 94% have separate ventilation systems. Almost half of the facilities allow smoking only in designated areas; the rest allow smoking outside