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Authors
Offen, Naphtali
Smith, Elizabeth
Malone, Ruth E

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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. ■

Kim Hamlett-Berry, PhD
Dana E. Christofferson, PhD
Richard A. Martinello, MD

About the Authors

The authors are with the Veterans Health Administration, US Department of Veterans Affairs, Washington, DC.

Correspondence should be sent to Kim Hamlett-Berry, PhD, Department of Veterans Affairs, 810 Vermont Avenue (10P3B), Washington, DC 20640 (e-mail: kim.hamlett@va.gov). Reprints can be ordered at http://www.ajph.org by clicking the "Reprints" link.

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Contributors

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

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References

1. Offen N, Smith EA, Malone RE. "They're going to die anyway": smoking shelters at veterans' facilities. *Am J Public Health.* 2013;103(4):604–612.
2. Department of Veterans Affairs. 2011 survey of veteran enrollees' health and reliance upon VA. Available at: http//www.va.gov/healthpolicyplanning/soe2011/soe2011_report.pdf. Accessed March 22, 2013.
3. Centers for Disease Control and Prevention. Current cigarette smoking among adults—United States, 2011. *MMWR Morb Mortal Wkly Rep.* 2012;61(44):889–894.
4. US Department of Veterans Affairs. *Smoking and Tobacco Use Cessation Report–2005.* Washington, DC: Veterans Health Administration, Office of the Assistant Deputy Under Secretary for Health for Policy and Planning; 2006.
5. US Department of Veterans Affairs. *Smoking and Tobacco Use Cessation Report–2010.* Washington, DC: Veterans Health Administration, Office of the Assistant Deputy Under Secretary for Health for Policy and Planning; 2010.
6. Arvey SR, Malone RE. Advance and retreat: tobacco control policy in the US military. *Mil Med.* 2008;173(10):985–991.

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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

> a specified distance from buildings. VHA Circular 10-90-141 (November 23, 1990) prohibits employees from using indoor smoking areas intended for patients, so they must smoke outside.[1(pp. 276-277)]

We are delighted to hear that the US Department of Veterans Affairs (VA) has made further strides in addressing tobacco use among VA-enrolled veterans, and in no way intended our work to imply that these efforts are not being made. Rather, our concerns focused on the way outside influences from the tobacco industry and its allies resulted in VA initiatives being thwarted by Congressional action. The phrase "advance and retreat" referenced an article about the Department of Defense and active service branches, but this case study certainly resulted in a retreat for those VA leaders who sought to institute reasonable smoke-free policies. We thus used the phrase in a broadly illustrative way, referencing the similar pattern we found with our active duty military study. We did not intend to suggest that the VA and Department of Defense are the same entity. ■

Naphtali Offen, BS
Elizabeth Smith, PhD
Ruth E. Malone, RN, PhD

About the Authors

Naphtali Offen, Elizabeth A. Smith, and Ruth E. Malone are with the Department of Social and Behavioral Sciences, School of Nursing, University of California, San Francisco.

Correspondence should be sent to Naphtali Offen, University of California, San Francisco, Department of Social and Behavioral Sciences, 3333 California St., Suite 455, San Francisco, CA 94118 (e-mail: naphtali.offen@ucsf.edu). *Reprints can be ordered at http://www.ajph.org by clicking the "Reprints" link.*

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References

1. Institute of Medicine. *Combating Tobacco Use in Military and Veteran Populations*. Washington, DC: National Academies Press; 2009.