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Editorials

Smoking bans in restaurants: who is responsible and who needs protection?

With growing evidence for the harmful effects of environmental tobacco smoke (ETS) on health,[1–3] there has been an increasing commitment to providing smoke-free public places.[4–6] The workplace, as the principal site of exposure to ETS among adults who do not live with smokers, has been the main focus of smoke-free policy activity,[7] and this trend has been accompanied by a growing acceptance among workers and the public of smoke-free environments.[5,8,9]

In contrast with the general workplace trend, the hospitality industry, through tobacco industry-supported organisations such as Restaurants for a Sensible Voluntary Policy, has actively resisted the introduction of smoke-free dining establishments.[10] This resistance has been framed in terms of either the rights of restaurant owners to regulate their own establishments or restaurateur perceptions of high demand by customers for smoking areas.[11,12] Neither of these arguments can stand. Firstly, the rights of business owners do not override the rights of customers or employees to an environment free from ETS.[13] Secondly, research has shown that both the general public and restaurant customers overwhelmingly support the provision of smoke-free dining.[9,12]

A limitation of past research on community and customer attitudes toward smoking bans in restaurants is that participants were asked their general opinion on the topic. It is well recognised, however, that general attitudes may not reflect actual behaviour in particular situations. The study reported by Andrews in this issue adds to the literature by reporting trends in actual customer choice of smoking or non-smoking areas in one restaurant in New South Wales, Australia over a four-year period.[14] The study reports increasing customer demand for smoke-free dining over the period from 55% of customers in 1990–91 to 73% in 1993–94. Further research is needed to determine how widespread this single case finding is; it is consistent, however, with research suggesting that most of the public are bothered by ETS[15] and think that smoke-free areas should be provided in restaurants and licensed premises.[12,16] A strength of the Andrew's study was that almost all customers were asked by staff for their preference for seating when they booked. Thus the findings reflect the actual choices of customers. This overcomes the problem of restaurateurs relying solely on the views of a vocal minority. Furthermore, it represents a relatively simple means of highlighting the passive smoking issue for the general public and raising its awareness in the community.

The Nordstrom and DeStefano paper in this issue reviews the provision of non-smoking areas from 10 studies spanning four Western countries: the US, Canada, Australia, and England.[17] They highlight the low rate of provision of totally smoke-free dining venues and indicate that, where non-smoking seats are provided, they make up less than 50% of all seats. This rate is thus well below the proportion of non-smokers in the community and fails to reflect the high rate of reported customer preferences for non-smoking areas.[12,14]

Given the failure of the self-regulation approach to provide adequate smoke-free areas in restaurants,[12] legislated provision of smoke-free areas is seen increasingly to be the most appropriate public health approach.[10,18] Little research has been carried out to examine how effectively such legislation has been implemented. The literature on the effectiveness of the sales-to-minors legislation, however, demonstrates that legislation alone does not guarantee effective implementation and enforcement.[19] Nordstrom and DeStefano report on the presence of required signs and the proportion of non-smoking seats in 18 restaurants in a college town in Wisconsin, where legislation has prohibited smoking except in designated areas since 1984.[17] Only 23% of restaurants had the required signs displayed and only 44% designated more than 50% of seats as non-smoking, suggesting that the legislation has been poorly implemented and enforced.

Given the potential for legislation to significantly reduce the salience of smoking as a socially acceptable public activity, there is a need to consider what is effective legislation, and what methods best ensure that it is effectively implemented and maintained over time. The most effective legislative option is clearly a total smoking ban in restaurants. This option has rarely been implemented, however, largely due to the active lobbying of the restaurant industry.[10] The best fallback option is to ensure that the requirements for the amount of non-smoking seating reflect the level of customer demand. This involves legislation that requires restaurants to provide a fixed minimum amount of seating as non-smoking (usually ranging from 50–75%). Such a strategy ensures some protection for customers, given findings which suggest that ETS concentrations are lower in non-smoking compared with smoking areas of restaurants.[20]

Although such legislation was first enacted in some states of the US as early as 1974, the pace of change has been much slower outside the country. For instance, the first smoke-free indoor environments legislation was passed in Australia as recently as 1994, the Australian Capital Territory's Smoke-free Areas (Enclosed Public Places) Act 1994. Smoking in restaurants was restricted to a maximum of half the area set aside for the consumption of food or non-alcoholic drink in the first instance, increasing to total bans or an exemption which requires at least 75% of the public area to be non-smoking beginning in December 1995.

This focus on partial versus total bans presupposes that customers are the only individuals at risk. Restaurant

employees spend much more time exposed to ETS in restaurants than do customers, however, and thus are more likely to suffer adverse health effects.[21] A major review of studies involving 1000 offices, and more than 400 restaurants and 600 homes, found that levels of ETS in restaurants were 1.6 to 2.0 times higher than in other workplaces and 1.5 times higher than in homes with at least one smoker.[21] Furthermore, epidemiological evidence suggests a 50% increase in lung cancer risk among food service employees that is at least partly attributable to exposure to ETS in the workplace.[21]

Thus evidence from studies of exposure levels and customer demand suggests that legislation is necessary to protect employees and customers. The role of litigation in increasing the number of smoke-free restaurants or provision of smoke-free areas in restaurants is likely to become more prominent with an increasing number of successful cases providing compensation for workplace exposure to secondhand smoke. The case of Liesel Scholem in 1992 in Australia has been seen as a catalyst for accelerating the introduction of smoke-free policies in the workplace in NSW.[22] A survey of workplaces in Sydney, undertaken about eight weeks after the Scholem decision, showed that 89% of companies reported being aware of recent legal developments and more than half the 359 companies interviewed could name the Scholem case.[23] Of those who were aware of legal developments, 42% reported that the decision had had an impact on their smoke-free policy. Such cases have the potential to significantly increase the pace of change in this important area of exposure to ETS.

Evidence is also accumulating to debunk concerns about the impact of smoking legislation on restaurant sales, a major barrier held up in the past by restaurateurs, or the tobacco industry under the guise of restaurant organisations, to slow progress towards smoking bans in restaurants. Samuels and Glantz document the unsubstantiated claims by restaurant organisations of substantial reductions in income following the introduction of smoking bans.[10] A recent analysis, however, of centralised restaurant sales data in California from 1986 to 1993 across 15 cities that introduced legislation and 15 cities selected as controls, showed no effect on the fraction of total retail sales that went to restaurants or on the ratio of restaurant sales in legislation versus matched control communities.[24]

Restaurants are the most frequented public venue in the US[25] and the highest source of exposure to ETS.[21] Despite a favourable trend over time in the number of states with restrictions on smoking in restaurants, further action is needed to strengthen existing legislation, to disseminate legislative change more widely, and to develop effective implementation and enforcement strategies to ensure protection of both employees and customers.

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Signal and noise in minimal interventions for smoking cessation

In this issue of *Tobacco Control*, Slama *et al*[1] demonstrate the efficacy and potential public health benefit of a nearly effortless smoking cessation intervention delivered by French general practitioners. Although Slama *et al* acknowledge the methodological limitations of their trial, it is important to note that their data dovetail with an international body of findings that strongly attests to the efficacy of minimal clinical interventions with patients who smoke.[2–4] The take-away message, the "signal" of the trial by Slama *et al*, therefore, is the imperative that physicians and clinics must intervene with all smokers, because even brief advice to quit will have a positive, cumulative impact.

The paper by Slama *et al* is valuable in another way; it illustrates how researchers in smoking cessation must struggle with methodological challenges, or "noise", germane to the evaluation of minimal clinical interventions. In essence, Slama *et al* and other researchers have detected and communicated the value of minimal