



Editorial

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Smoking, restaurants and bars: the Toronto experience

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No physician needs to be reminded of the importance of minimizing exposure to environmental tobacco smoke; the health consequences of such exposure are well known.^{1,2} For many Canadians, exposure to the irritating and harmful products of tobacco combustion most often takes place in the shared public spaces of restaurants and bars. The effects of exposure in these settings are known to be detrimental to the health of both employees and customers.³

Public health officials and tobacco control experts are now reviewing events that have taken place in Toronto over the past 18 months, since measures to control exposure to tobacco smoke in restaurants and other facilities were first introduced as a municipal bylaw in July 1996. Other Canadian municipalities, including Vancouver, are also grappling with this issue. The original Toronto bylaw was compromised through the political mischief of those who believed it could be defeated if its provisions covered both restaurants and bars without exemption. The bylaw passed anyway, but with perhaps predictable consequences: the process faltered following the protests of restaurateurs, bar owners and members of the public in an environment that could best be described as confusing. Modified, less-than-ideal regulations emerged in April 1997 after the issue had been twice revisited by a harried Toronto City Council.

Currently, proprietors of restaurants occupying less than 100 m² can provide no more than 10 m² or 25% of the usable seating area (whichever is less) as unenclosed smoking space. In facilities larger than 100 m², a proprietor can designate up to 10 m² of unenclosed seating area as smoking space. If a smoking area is enclosed and ventilated, it may occupy up to 50% of the usable seating area. By 2000, all premises must be smoke free or provide separately enclosed, ventilated smoking areas; building permits for the construction of specific smoking areas will no longer be granted after that date.

Much of the opposition to such bylaws comes from the hospitality industry, which fears a decline in sales. Such views rest on the assumption that smokers will stay away from smoke-free facilities. They completely ignore the facts that nonsmokers are in the overwhelming majority, that they outspend smokers in restaurants by a factor of 2.5 and that they welcome the opportunity to dine in an environment where the air is clean and fresh.⁴

In other jurisdictions, smoking has been successfully eliminated from restaurants and bars with broad public acceptance and no decline in restaurant sales. Careful and elegant analyses of the economic consequences of smoking control by-laws in a number of US cities have shown that business and sales can actually increase when restaurants become smoke-free.⁵⁻⁸ The conclusions of these studies stand in marked contrast to those of the "reports" often cited by restaurant associations and sponsored and distributed by tobacco interests.⁹ There is ample support for the conclusions of the Center for Hospitality Research of Cornell University's School of Hotel Administration that "restaurateurs should make business decisions based on data, not opinion. . . . Ultimately, smoke-free legislation is likely to have a positive impact on restaurant industry revenues."²

What lessons can be learned from the Toronto experience? Make haste slowly. Although there should be no delays in the development of bylaws to eliminate smoking from bars and restaurants, the ground should be carefully prepared in advance of their application. For example, Toronto's restaurateurs were visited by



public health inspectors and advised of the nature of the new regulations, but not until the day the regulations came into effect — and with predictable results. There must be time to carry out appropriate community education strategies that involve the hospitality industry, an industry that needs to learn more about the problems posed by exposure to environmental smoke (particularly for employees) and the advantages of a smoke-free environment from both a health and an economic point of view.

How can such bylaws be enforced? In Toronto, restaurant managers were simply required to notify customers of the provisions of the bylaw; in many establishments, the original regulations were soon honoured more in their breach than in their observance. Proprietors must be made as responsible for upholding such bylaws as they are for ensuring compliance with other public health, food, fire and safety regulations.

In retrospect, it seems that attempting to make restaurants and bars smoke free simultaneously was a mistake. That the original bylaw was amended to produce such an approach was unfortunate. The experience of the State of California, where smoking was first eliminated in restaurants and later banned in bars, is salutary.¹⁰

The public is strongly in favour of measures to eliminate exposure to second-hand smoke. Toronto's attempt to establish smoke-free restaurants and bars, although perhaps falling short of the ideal, represents real progress and will serve as a bell-wether for other communities.

Public health officials must learn from that experience and develop approaches that can be introduced in ways that are both strategic and sensitive — approaches that Canada's physicians should strongly, and publicly, support.

References

1. Law MR, Morris JK, Wald NJ. Environmental tobacco smoke exposure and ischaemic heart disease: an evaluation of the evidence. *BMJ* 1997;315:973-80.
2. Hackshaw AK, Law MR, Wald NJ. The accumulated evidence on lung cancer and environmental tobacco smoke. *BMJ* 1997;315:980-8.
3. Siegel M. Involuntary smoking in the restaurant workplace: a review of employee exposure and health effects. *JAMA* 1993;270:490-3.
4. Corsun DJ, Young CA, Enz CA. Should New York City's restaurateurs "lighten up"? Effects of the Smoke-Free Air Act. *Cornell Hotel Restaurant Admin Q* 1996;3:25-33.
5. Glantz SA, Smith LRA. The effect of ordinances requiring smoke-free restaurants on restaurant sales. *Am J Public Health* 1994;84:1081-5.
6. Maroney N, Sherwood D, Stubblewine WC. The impact of tobacco control ordinances on restaurant revenues in California. Claremont (CA): Claremont Institute for Economic Policy Studies, Claremont Graduate School; 1994.
7. Assessment of the impact of a 100% smoke-free ordinance on restaurant sales — West Lake Hills, Texas, 1992-1994. *MMWR* 1995;44:370-2.
8. Pope GC, Bartosch WJ. *Effect of local smoke-free restaurant policies on restaurant revenue in Massachusetts*. Waltham (MA): Center for Health Economics Research; Apr 1997.
9. Review of studies of the economic impact of 100% smoke-free restaurant ordinances commissioned by the US tobacco industry. Berkeley (CA): Americans for Nonsmokers' Rights; 1993.
10. Smokefree bars, taverns and gaming clubs in California. Berkeley (CA): Americans for Nonsmokers' Rights; 1997. (Also available: www.no-smoke.org/ca-bars.html)

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