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Research Report

Health Care Organizations and Policy Leadership: Perspectives on Nonsmoker-Only Hiring Policies

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Abstract

Purpose

To explore employers' decisions to base hiring policies on tobacco or nicotine use and community perspectives on such policies, and analyze the implications for organizational identity, community engagement, and health promotion.

Method

From 2013–2016, 11 executives from 6 health care and 1 non-health care organizations with nonsmoker-only hiring policies were interviewed about why and how their policies were created and implemented; concerns about the policies; and perceptions of employee and public reactions. Focus groups were conducted with community members (n = 51) who lived in or near cities where participating employers were based, exploring participants' opinions about why an employer would stop hiring smokers and their support (or not) for such a policy.

Results

Most employers excluded from employment those using all forms of nicotine. Several explained their adoption of the policy as a natural extension of a smoke-free campus and as consistent with their identity as health care organizations. They regarded the policy as promoting health. No employer mentioned engaging in a community dialogue before adopting the policy or reported efforts to track the policy's impact on rejected applicants. Community members understood the cost-saving appeal of such policies, but most opposed them. They made few exceptions for health care organizations.

Conclusions

Policy decisions undertaken by health care organizations have influence beyond their immediate setting and may establish precedents that others follow. Nonsmoker-only hiring policies may fit with a health care organization’s institutional identity, but may not be congruent with community values or promote public health.

Academic medical centers serve as role models for other health care organizations and are regarded as authoritative voices in their communities.[1] Thus, when academic medical centers adopt new policies, their impact may be far-reaching. Organizational theory suggests health care organizations may adopt new policies after careful consideration because they benefit the organization, and over time, all health care organizations that stand to benefit from them will adopt the new policies.[2,3] Alternatively, the process of diffusion may be less rational, with health care organizations imitating one another because they are forced to do so (e.g., by governmental bodies), they are following trends established by "fashion setting" from outside organizations or the public, or they are seeking a competitive or reputational advantage in adopting other health care organizations' practices and norms.[3–6]

In 2007, the Cleveland Clinic became one of the first academic medical centers to no longer hire employees who smoked to "preserv[e] and improve[e] the health of … employees and patients."[7] There is considerable controversy about the ethics of nonsmoker-only hiring policies,[8–15] with most of the U.S. public (86%) disapproving of such policies,[16] Furthermore, the impact of these types of policies on smokers has not been investigated. Nonetheless, in the 21 states where such policies are allowed by law, other academic medical centers and health care organizations have followed the Cleveland Clinic's example, more so, apparently, than other types of employers: Among the 4% of large employers who reported not hiring smokers in a 2013 survey, hospitals were the most likely type of employer to do so.[17]

Whether nonsmoker-only hiring policies are adopted by health care organizations or other employers for reasons of efficiency or imitation is unknown, as no previous studies have

explored how and why such policies are adopted. The nuances of public opinion regarding such policies have also not been examined. For example, it is unknown if approval of such policies is higher when they are being implemented by health care organizations. In this paper, we explore the decision by health care organizations and other employers to base hiring decisions on tobacco or nicotine use (for simplicity's sake, we refer to all of these policies as nonsmoker-only policies) and community responses to such policies, and analyze the implications of our findings for organizational identity, community engagement, and health promotion.

Method

The study was approved by the University of California, San Francisco's Committee on Human Research (IRB #10-00850). We agreed not to reveal the names of employers or anyone we interviewed.

From 2013 to 2015, we identified U.S. employers who had established nonsmoker-only hiring policies within the prior three years (to ensure adequate recall) by conducting Google searches using terms such as "stop," "ban," or "no longer"; "hire" or "employ"; and "smokers" or "tobacco users." Search results were typically news items about specific employers—mostly health care organizations—that had adopted such a policy. The first author (P.A.M.) then contacted via phone 24 employers (a mix of health care and non-health care organizations), asking to speak to the executive identified as being responsible for the policy in the news items or those who were integral to or knowledgeable about the creation of the policy, making a minimum of six attempts to reach employers. Seven of these employers agreed to participate, and 2 declined. The remaining 15 failed to respond to repeated calls. Six of the 7 participating

employers were health care organizations (Table 1). The remaining employer was in the food service and entertainment industry.

From 2013–2016, P.AM. conducted eleven 20–30 minute audiotaped telephone interviews with 1–2 executives from each participating employer, including representatives from human resources, public relations, and employee health and wellness departments (Table 1). Questions concerned why and how the nonsmoker-only hiring policy was created and implemented; concerns about the policy; and perceptions of employee and public reactions (see Supplemental Digital Appendix 1 at [LWW INSERT LINK]). We did not attempt to reconcile differences in responses between interviewees from the same employer. In the Results, we identify interviewees by an employer number and their job title.

From 2013–2016, we also conducted seven focus groups with community members who lived in or near cities where the 7 participating employers with nonsmoker-only hiring policies were based. We recruited focus group participants via Craigslist, a classified ads website, and flyers at local community centers and libraries. Our eligibility requirements were that participants had to be 18 or older, able to speak and read English, and a resident in or near a city that was home to an employer that was participating in our study. Participants called a toll-free number and were screened by a project assistant to ensure eligibility. See Table 2 for the focus group participants' demographics, which were collected via a questionnaire at the beginning of the focus group session.

Focus group sessions typically lasted 1.5 hours and included between 4 and 9 participants (n = 51). Discussions were moderated by one of two experienced researchers (P.A.M. or a research assistant), using a low moderator involvement approach.[18] Questions focused on participants' opinions about why an employer would stop hiring workers who smoked, participants' support (or not) for such a policy, and whether support varied by the type of employer who adopted the policy (see Supplemental Digital Appendix 2 at [LWW INSERT LINK]). Participants were given $40 for their participation. In the Results, we identify focus group speakers as current tobacco users (CTU), former tobacco users (FTU), or never tobacco users (NTU) and with a focus group (FG) number.

Interview and focus group transcripts were transcribed by professional transcriptionists and checked for accuracy by P.A.M. and the research assistant. P.A.M. coded the transcripts using a codebook developed for a previous study examining why retailers voluntarily ended tobacco sales.[19] In that project, four coders, including both authors, created a codebook through an iterative process of data review and discussion.[19] We used NVivo version 9 software (QSR International Pty Ltd., Melbourne, Victoria, Australia) for data management.

We analyzed coded interview and focus group data for themes related to organizational identity, community engagement, and health promotion using conventional qualitative content analysis, which involves identifying themes or patterns in systematically coded text.[20] We chose quotes that were most representative to present in the Results.

Results

Scope and implementation of hiring policy

Surprisingly, all but one of the employers in our study excluded from employment not only those using tobacco but also those using any form of nicotine, including nicotine replacement therapy (NRT) and e-cigarettes. Employer 5 was the exception, considering NRT users eligible for employment. All employers used a similar process to screen applicants, starting with early notification about their nonsmoker-only hiring policies. For example, employer 1 required applicants to confirm in an online application their understanding "that [Employer 1] does not hire people who use tobacco or nicotine products" (vice president of recruitment). For all employers, job offers were contingent upon passing a drug test with a nicotine panel, which tests for cotinine. Employer 5 screened for nicotine "within a certain range" such that NRT users were not flagged (chief human resources officer). All employers allowed those who failed the screening to reapply for an available position in 3–12 months. Although all of the health care organizations in our study offered current employees access to smoking cessation services, only one (employer 5) offered such services to applicants who failed the screening.

For all of the health care organizations in our study, their policies only affected new hires; the remaining employer started with the policy and had no pre-existing workforce. Interviewees did not indicate any type of prospective employee as being exempt from the hiring policies, with some explicitly mentioning nurses, physicians, neurosurgeons, and residents as bound by the policies.

Policy drivers

Before implementing these hiring policies, all of the health care organizations in our study had established tobacco-free campuses, with tobacco use prohibited anywhere on the grounds. In addition, all but two of the employers (employer 2 and employer 4 [which had no smoking employees]) also required existing employees who were tobacco and, in some cases, e-cigarette users to pay more for health insurance. Several interviewees claimed the tobacco-free campus policy led "naturally" to or "evolved" into the hiring policy. For example, employer 2's vice president of human resources stated:

> [G]oing smoke- and tobacco-free … was the first step we took. And then along the way there were casual discussions about not hiring smokers. And once we … moved to smoke- and tobacco-free and … saw how that evolved, we had a lot of discussion about taking the next step, which was to not hire smokers.

When asked if there was "an issue with going tobacco-free that you thought going smoker-free would solve," the same interviewee replied "no" and re-emphasized that the two policies were interconnected:

> We weren't sure how the whole thing would unfold. So … we took the first step to go smoke- and tobacco-free, and the second step was not to hire smokers. (vice president of human resources, employer 2)

For employer 5, the recent acquisition of a health care organization that had adopted the hiring policy four years before served as the inspiration for adopting the policy. All health care organizations were aware of others that had adopted similar policies, and three mentioned the Cleveland Clinic as a role model, with one noting the clinic also served as a frequent benchmark. When asked whose idea it was initially to adopt their policy, three employers identified the chief executive officer or senior executive leadership, two named the human resources department, and two identified a regional association or corporate parent.

Overall, employers gave two explanations for adopting the hiring policies: promoting health and reducing health insurance costs. All of the health care organizations claimed an interest in promoting health as a motivation, with most linking the decision to their health care missions or culture of health. For employer 1's assistant director of wellness, the policy was part of "the whole strategy of our health and wellness culture." Several employers saw themselves as health promotion leaders and the hiring policy as an opportunity to set an example for employees, patients, and the community. Employer 5's chief human resources officer explained:

> It's consistent with our mission … we're a health organization and feel as though we should take a leadership role in trying to curb unhealthy behaviors. … [and] create a healthier community.

Employer 3's vice president of health and wellness stated the organization's leaders had concluded "if we're going to be a … leading health care organization, we need to practice what we preach."

However, no employer mentioned seeking community input when considering adopting the policy. The vice president of public relations for employer 3 stated "we didn't know whether it was going to be popular or not." Employer 2's vice president of human resources noted "as a reality check on some of the decisions we were making," regarding the tobacco-free campus policy, "we … had smokers on the committee" but did not do something similar for decisions regarding the hiring policy because "we felt that we were well down that road and that was just the next natural step."

Most interviewees left unspoken the assumption that for the hiring policy to promote health, it would have to inspire smokers to quit smoking (or nonsmokers to not start) rather than to seek employment elsewhere or remain unemployed; however, three addressed this explicitly. Employer 6's vice president of human resources noted "for every person we touch that makes a decision to either not start smoking or to stop smoking … then we're doing what we're trying to do." The vice president of recruitment for employer 1 described the organization's role as helping those who failed the nicotine screening to "get healthy and well" by pointing them to smoking cessation services. While employer 5's chief human resources officer noted county smoking prevalence rates had declined since their policy was adopted, no interviewees reported efforts to track rejected applicants' use of smoking cessation services or ability to obtain alternative employment.

Reducing employee-associated health insurance costs was mentioned as a policy motivation by interviewees representing employers 4 and 7. Employer 4's director and assistant director of human resources stated the organization was "big on wellness in general" as a means of saving money. Similarly, employer 7's director of employee health stated they had adopted the hiring policy "to help in the costs of … health care insurance provided by the organization" (although employer 7's vice president of human resources claimed the policy was adopted solely to achieve consistency with the organization's health care mission). When asked if the monetary savings message was communicated to employees, the director of employee health for employer 7 responded "of course not," describing communications on the policy as wellness-focused instead.

Policy uncertainties

Interviewees indicated employers' main concern about the hiring policy was its potential to negatively impact recruitment. Employer 1's vice president of recruitment, for example, noted they had a limited pool of applicants to draw on, given their rural location, and the food services department was particularly concerned about the policy's impact on hiring. Employer 5's chief human resources officer was concerned about cyclical hiring shortages: "Are we going to put ourselves at a disadvantage [with] being able to get enough quality [nurses, physicians, and so forth] … when the market turns?" As it turned out, only the non-health care employer found the hiring policy had indeed negatively impacted recruitment, specifically, the recruitment of cooks and chefs. All of the health care organizations asserted they had experienced no hiring difficulties, and several stated the policy offered them an advantage by "attracting more people to us" (vice president of human resources, employer 7) or weeding out less serious applicants.

In part, the health care organizations managed uncertainties about their policies by contacting peers (including the Cleveland Clinic) who had already adopted similar hiring policies to share knowledge, procedures, protocols, and communication strategies. For example, employer 3's vice president of health and wellness visited the Cleveland Clinic and discussed "when … they [implemented the policy and] what were lessons learned" and "developed talking points based upon their feedback."

Perceived employee and public response

Employee response to the hiring policies, as reported by the employers, ranged from a mix of positive and negative (with smokers typically having a more negative reaction) to largely

positive; no employers reported a highly negative employee reaction. Several interviewees attributed the positive response to the policy only applying to new hires, so employees "knew that if they were smokers they weren't going to be fired" (vice president of health and wellness, employer 3). In the case of employer 4, which had no pre-existing workforce, interviewees reported having the policy in place from day one led to greater acceptance, as "that's … all that anybody knows" (assistant director of human resources).

Among health care organizations, interviewees also reported the hiring policy either improved or had no impact on employee morale. Those who asserted the policy had no impact stated other events, like a healthy cafeteria foods initiative or eliminating outdoor smoking areas, were more controversial among employees. Those stating the policy had improved employee morale said it had demonstrated the organization cared about "the wellness of our employees" (vice president of health and wellness, employer 3).

Most employers mentioned some negative public response to the hiring policy, pointing to critical comments on social media or in local newspapers. Commenters accused the employers of overreaching and questioned whether additional hiring restrictions (e.g., weight-based restrictions) were now inevitable. Public outcry was typically short lived, however, with the vice president of recruitment for employer 1 calling it "a tempest in a teapot" that lasted several weeks "and then after that—we heard nothing." Similarly, employer 6's vice president of human resources noted the "hits" they took through social and news media "went away pretty quickly."

Community response

While not all focus group participants were familiar with employers' nonsmokers-only hiring policies, most could understand their appeal. They assumed smoking employees incurred extra health care costs and the hiring policy would save employers money. Some also regarded smokers as less productive than nonsmokers, as smokers might take more breaks, miss more work due to tobacco-related illnesses, or focus less on their work because they were "thinking about that [next] cigarette" (FTU, FG 4). Few suggested the employers' interest in health promotion inspired the policies. When the idea was raised in one focus group, other participants scoffed and one stated he did not believe employers "have that much of my interest at heart" (CTU, FG 5).

Despite recognizing why employers might choose not to hire smokers, the majority of focus group participants, regardless of location or tobacco use status, were opposed to the policies. In three focus groups, all or nearly all participants expressed opposition, while in the remaining four focus groups, most participants expressed opposition or mixed feelings. One of the most common reasons for opposing the policies, raised in nearly every focus group, was a concern that acceptance would lead to further hiring restrictions. For example, one participant stated "it's going to progress to other things. It's going to go to weight, it's going to go to … alcoholic beverages" (FTU, FG 4). Once you opened the door to one type of employment restriction "everything walks in" (NTU, FG 2).

Focus group participants also frequently viewed the policy as an unacceptable restriction on personal freedoms, with several asserting people had a "right to smoke" (FTU, FG 5). Others emphasized the right to privacy, noting "what you do in your time is your business" (CTU, FG 6)

and “[telling] somebody that you can’t engage in a legal activity anywhere, or we won’t hire you … is really stepping over the line on … infringing on what I do in my personal life” (FTU, FG 3).

A third common objection was that the policy discriminated against smokers. Some compared it to illegal forms of employment discrimination: “If I can’t not hire you because you’re black … then why can I say, ‘Well, you’re a smoker’?” (CTU, FG 3). Others saw the policy (particularly when justified as a way to reduce health care costs) as discriminatory because it unfairly singled out smoking as a health risk:

> What’s the difference between a diabetic, a person … that has high cholesterol? A person that is an epileptic or has a disability? What’s the difference in a person that smokes or a person that has cancer and it’s in remission? (CTU, FG 6)

Despite this opposition, in approximately half of the focus groups, some participants identified health care organizations as employers for whom a nonsmoker-only hiring policy might make sense. Their reasoning centered on the poor fit between health and smoking, with one participant noting “I would feel … weird if I smoked and I worked with [patients with lung cancer]. … I would be less offended [by the policy in] a place like that” (FTU, FG 3). Some participants also drew on their experiences as patients, wondering “What if you’re putting an IV into my arm and you’re jonesing for a cigarette?” (CTU, FG 1) However, there was no broad agreement among focus group participants on the exceptional nature of health care organizations, with, for example, one pointing out “if my doctor smoked and I had a problem with it, I would find another doctor” (FTU, FG 3) and another asking “How would you feel if you went to school for years and paid all this money and … now the hospital won’t hire you?” (CTU, FG 3)

A few focus group participants identified possible alternatives to refusing to hire smokers that might achieve similar financial or health objectives, including charging tobacco users more for health care premiums or prohibiting smoking during the workday. Several also suggested tobacco users be excluded from employers' health care plans entirely, agreeing tobacco users would have to "get insurance somewhere else" (FTU, FG 4). Some participants offered other creative solutions, including making the tobacco industry responsible for helping smokers quit smoking (CTU, FG 2) or having employers offer smokers an incentive to quit, such as paying "a month's worth of your rent" (CTU, FG 3).

Discussion

Despite the continuing adoption of nonsmoker-only hiring policies by health care organizations and academic medical centers since 2007, no research has explored the policy adoption process. Among the health care organizations in our study, we found all had established tobacco-free campuses and most had charged nicotine users more for health insurance before adopting these policies. Several interviewees saw the hiring policies as the natural next step after tobacco-free campuses, as they were consistent with their health care missions and efforts to model health-promoting practices to employees, patients, and the community. However, none of the participating health care organizations consulted with members of the community first or attempted to track the impact of the policies on rejected applicants' use of smoking cessation services or ability to obtain alternative employment. Overall, the community members in our study (including nonsmokers) disliked such policies, even when adopted by health care

organizations, regarding them as infringing on various rights and/or as discriminatory; most were also skeptical of claims that health promotion was an impetus for the policies.

Health care organizations appear to be adopting nonsmoker-only hiring policies in imitation of their peers, in an effort to maintain legitimacy and status by conforming to emergent norms.[3–5] Hiring employees who use nicotine, like allowing smoking on campus, has come to be seen as condoning tobacco use, which is an untenable position for health care organizations whose organizational identities are centered on health promotion. Thus, they seem to be willing to risk the uncertainties associated with such a policy—for example, a possible decline in the number of job applicants and public outcry—to maintain a consistent organizational identity.

It remains unclear how the two tobacco-related policies (i.e., tobacco-free campuses and nonsmoker-only hiring) came to be intertwined. Interviewees' suggestion that a smoke-free campus policy led "naturally" to a hiring policy implied the second policy was an inevitable outgrowth of the first. However, this may ignore key differences between the two, most notably the distinction between employee behavior on versus off the job and the ability to retain rather than lose employment opportunities. But the natural label may have created a sense of consistency with past practices that helped justify the hiring policy.

This is not the first time that a "fad" has influenced health care organizations' strategies.[6] But given the strong opposition to such policies from community members, health care organizations considering such measures should consider first seeking community input, and, if implementing such policies, measuring outcomes, especially among those not hired due to nicotine use.

Smoking is concentrated among the economically and socially disadvantaged,[21] and it is unknown whether these types of hiring policies inspire smoking cessation. Without such evidence, health care organizations may be undermining their missions by worsening health disparities between smokers and nonsmokers rather than promoting health. Another step that health care organizations who have adopted this type of policy might consider taking is extending smoking cessation assistance to applicants who fail the nicotine screening. Only one of the health care organizations in our study took this step; doing so would be consistent with one reason interviewees gave for adopting these policies—to promote health.

While our study focused solely on nonsmoker-only hiring policies, the issues raised may be of relevance to other policy proposals that health care organizations are considering. As cost containment becomes an increasingly important imperative, organizations may be tempted to consider other restrictive policies, such as increasing health insurance premiums for certain groups or dropping coverage altogether for employees who do not demonstrate healthy behaviors. Justifying such measures as a kind of benevolent paternalism on the part of employers ignores the potentially negative effects on the health and economic security of individuals who may already be disadvantaged in multiple ways.

An ongoing tension exists between public health policies, such as mandatory seat belt use, helmet laws, mandated vaccinations, and other similar measures, which aim to improve community health at the population level, and the necessary constraints on individual behavior that such policies often involve. Leaders, not just of hospitals but within communities, academic medical centers, and other health care organizations, should engage communities in a dialogue

about how to balance public health and institutional goals with concerns for individuals, and health professions education should encourage students to consider the ethical implications of such policies.

Limitations

Our study has limitations. There is no national list of employers who have instituted nonsmoker-only hiring policies, so our interviewees were drawn from a small number of employers identified through news items; thus, the employers in our study cannot be considered representative of all employers with such policies. Our affiliation with a health sciences university may have resulted in response bias among interviewees, leading them to overemphasize the role of health promotion in their decision to establish a nonsmoker-only hiring policy. Because our previous attempts to interview employees for related studies yielded few employee participants, we did not interview employees; thus, we had no "grassroots" perspective on these policies. Our study also offers limited insight into the decision making related to these policies by non-health care organizations, although we attempted to recruit such businesses. Finally, focus group members were a self-selected, nonrepresentative sample; thus, our findings cannot be generalized to all members of the communities from which they were drawn.

Conclusion

Academic medical centers have been urged to engage with communities and to broaden their conceptualization of engagement.[1,22] Our study suggests community engagement should

encompass not only community service, research, and education,[22] but also engagement regarding organizational policies likely to impact community members. Without this type of engagement, academic medical centers may undermine their mission of improving the community's health and reducing heath disparities.

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Table 1

U.S. Employers (n = 7) Participating in Interviews Regarding Nonsmoker-Only Hiring Policies, 2013–2016[a]

Employer	Employer type	Type of health care organization	Interviewees (n = 11)
1	Health care	Academic medical center[b]	• Vice president of recruitment • Assistant director of wellness program
2	Health care	Academic medical center[b]	• Vice president of human resources
3	Health care	Academic medical center[b]	• Vice president of health and wellness • Vice president of public relations
4	Non-health care	Not applicable	• Director of human resources • Assistant director of human resources
5	Health care	Academic medical center[b]	• Chief human resources officer
6	Health care	Community hospital affiliated with academic medical center[b]	• Vice president of human resources
7	Health care	Academic medical center[b]	• Vice president of human resources • Director of employee health

[a]Information collected via self-report in interviews and from news items.
[b]Defined as engaged in teaching, research, and patient care.

Table 2

Demographics of Individuals Participating in Focus Groups (n = 51)[a] on Nonsmoker-Only Hiring Policies, 2013–2016

	Focus group[b]					
Demographics	**1**	**2**	**3**	**4**	**5**	
Participants, no.	9	8	5	4	8	
Age range	36–58	26–60	32–59	29–48	29–62	27–6
Gender, no.						
Women	0	5	3	2	4	
Men	9	3	2	2	4	
Race/ethnicity, no.						
African American	6	3	3	1	5	
American Indian or Alaskan Native		1				
Hispanic white			1	1		
Multiracial						
Non-Hispanic white	3	4	1	2	3	
Tobacco user type, no.						
Current	8	3	2	2	3	
Former	0	2	2	1	2	
Never	1	3	1	1	3	2

[a]Participants had to be 18 or older, able to speak and read English, and a resident in or near a city that was home to an employer that was participating in the study (see Table 1).

[b]Focus group numbers correspond to employer numbers.