United States of America

BEFORE THE FEDERAL SERVICE IMPASSES PANEL

In the Matter of DEPARTMENT OF VETERANS AFFAIRS VETERANS HEALTH SERVICES AND RESEARCH ADMINISTRATION WASHINGTON, D.C. and NATIONAL VA COUNCIL AMERICAN FEDERATION OF GOVERNMENT EMPLOYEES, AFL-CIO	Case No. 89 FSIP 198

FACTFINDER'S REPORT

The National VA Council, American Federation of Government Employees, AFL-CIO (Union) filed a request with the Federal Service Impasses Panel (Panel) to consider a negotiation impasse under section 7119 of the Federal Service Labor-Management Relations Statute (Statute) between it and the Department of Veterans Affairs, Veterans Health Services and Research Administration, Washington, D.C. (VHS&RA or Employer). The undersigned was appointed by the Panel to conduct a factfinding hearing and make recommendations for settlement on issues concerning a nationwide smoking policy for the Employer's health care facilities. The hearing was held on November 1 and 2, 1989. A stenographic record was made, testimony and arguments were presented, and documentary evidence was submitted. The parties filed posthearing briefs.1/

1/ After the close of the hearing, the Employer filed a Motion To Strike which was received by the Office of the Executive Director, Federal Service Impasses Panel on December 15, 1989. On January 9, 1990, the Executive Director received a letter from the Union objecting to the Employer's motion as improperly before the undersigned. Under section 2471.8(a)(1) of the Panel's rules and regulations, motions are made either during the prehearing conference or during the conduct of the hearing. Pursuant to section 2471.8(a)(5), this procedural matter was made known to the parties at the start of the hearing (Tr. 6). Therefore, as the Employer has offered no reason nor is there one apparent why conformance with the Panel's rules and regulations could not be met, it's motion is hereby dismissed.

BACKGROUND

The Employer's mission is to develop, maintain, and operate a national health care delivery system for eligible veterans; carry out a program of medical care research and educating and training health care personnel; and furnish health services to members of the Armed Forces during a war or national emergency (FF. Exh. 1(c); Jt. Exh. 1). The Union represents approximately 118,000 employees of which 107,000 work at VHS&RA facilities. The VHS&RA consists of medical centers, which comprise hospitals, nursing home care units, and domiciliary units; independent and satellite outpatient clinics, independent domiciliaries and clinics; and veterans outreach centers.

The dispute arose during negotiations following the Union's receipt in May 1989, of the Employer's proposed policy entitled "Smoke Free Environment in VA Health Care Facilities." The Employer's objective is to establish a smoking ban in all VHS&RA medical centers nationwide. (FF. Exh. 1(a) and (c); Jt. Exh. 1.) The master agreement between the American Federation of Government Employees and the Department of Veterans Affairs is due to expire on August 13, 1990.

THE ISSUE AT IMPASSE

The basic issue concerns to what extent shall designated smoking areas be maintained within Veterans Health Service and Research Administration medical centers under the Employer's smoke-free policy initiative.

POSITIONS OF THE PARTIES

Employer's Position

The Employer's proposal, to phase in over a 90-day period a smoking ban within all VHS&RA medical facilities, is based upon numerous scientific reports and the opinions of experts on the health hazards generated by environmental tobacco smoke (ETS), and its determination that a smoking ban is the only feasible means and practical method of achieving its smoke-free policy (Tr. 17-19, 57-73, 122-125; FF. Exh. 1(a); Emp. Exhs. 12 and 13; Emp. Br. p. 2). Significant among the Employer's proposed accommodations for employees who smoke are stress management and smoking cessation classes, and its encouragement to "local management ... to provide shelter from the elements for employees and patients who choose to smoke outside" (FF. Exh. 1(a)). In urging that the Panel rule similarly, the Employer cites a recent Panel Decision and Order in Department of the

Army, Fort Riley, Kansas and Local 2324, American Federation of Government Employees, 89 FSIP 59 (May 24, 1989), Panel Release No. 281, where the Panel adopted the employer's proposal that, in relevant part, there be no smoking within any of its medical facilities (Emp. Br. p. 3).[2/] The Employer further argues that since no threshold level of ETS has been established at which the attendant health risks are totally eliminated, there is no means of establishing risk-free designated-smoking areas (DSA) that would be effective and practical for a working environment[3/] and not cost prohibitive[4/] (Tr. 79, 88, 148). The health risks of ETS are further exacerbated due to

---

2/ The Panel based its decision on scientific studies which "have conclusively established that secondhand smoke is a health risk to nonsmokers." Note, however, that should the parties either not accept the recommendation of the factfinder or reach a settlement, the Panel is not bound by precedent but may, in accordance with section 2471.11(a) of its rules and regulations, "take whatever action is necessary and not inconsistent with 5 U.S.C. chapter 71 to resolve the dispute[.]"

3/ The Employer provided expert testimony that the establishment of a **de minimus** risk level of ETS (0.75 micrograms of smoke and tar per cubic meter of workplace air or an average of 1 death in 100,000 per working lifetime, i.e., 40 years) would require an impractical level of ventilation which is 226 times greater than the recommended standards, i.e., the equivalent of a "windstorm", for a typical office building "where smoking was not restricted" (Tr. 273-280). It would be impractical and the cost "excessive" to install or upgrade the existing ventilation systems in all medical facilities to meet such a capability (Tr. 307, 308).

4/ There are over 3,000 designated smoking areas currently in existence in VHS&RA medical facilities nationwide (Emp. Exh. 30; Emp. Br. p. 10; Un. Br. p. 2). It currently costs the Employer an additional $1,000 a year per room to ventilate a DSA, typically a dayroom of 300 square feet, over the cost to maintain that same room if smoking were not permitted (Tr. 315; Exh. 53). This estimate, however, is based on the cost of "remov[ing] most of the uncomfortable aspects of smoking", i.e., 12 air changes per hour, and not to achieve the **de minimus** risk level noted above with respect to the attendant health risks of ETS (Tr. 273, 305). It was also estimated that it would cost roughly $8,000 to $10,000 to convert ventilation systems in DSAs that did not have already the above capacity (Tr. 306, 311, 313). No figure was provided, however, on the number of DSAs which did not have this ventilation capability.

the high instances of asbestos that once existed in many of the medical facilities, most of which are very old (Tr. 219-220, 316-317). Prior to the removal or encapsulation of the asbestos, employees had been exposed to it. Exposure to both asbestos and ETS has a "synergistic" (multiplicative) effect. Continued exposure to ETS will only serve to magnify the potential health problems. (Tr. 74, 81-82; Emp. Exh. 11.) Thus, the easiest way to remove the dangers of exposure to ETS is to remove the source, i.e., smoking (Tr. 79). Moreover, the Employer argues that by eliminating an unhealthful environment, its smoking ban proposal is consistent with its mission as the nation's largest health care provider and thereby promotes public policy (Tr. 127, 130). This mission objective is further accentuated due to the high incidences of smoke-related diseases treated in VHS&RA medical facilities as a result of the historic use of tobacco by the military (Tr. 97, 119-125, 136-137, 359; Emp. Exh. 24). The adoption of a smoking ban is not only the emerging method of choice among hospitals to achieve an environment free of the harmful effects of ETS, it is also the consensus among noted medical associations[5/] (Tr. 25-29, 89, 121-124, 128, 130, 133-134, 258; Emp. Exhs. 4-9, 24, 28, 29). The lack of employee example that would result from employees smoking in accommodations within medical facilities would serve only to undermine the Employer's efforts in this regard (Tr. 136, 137, 169; Emp. Br. p. 2 and 3).[6/]

Furthermore, scientific studies have established that withdrawal symptoms of employees "addicted" to smoking do not appear until 8 hours after their last indulgence and peak after

---

5/ These medical associations include the American Academy of Pediatrics, the American College of Physicians, the American Medical Association, and the American Hospital Association.

6/ The Employer argues that its proposal is not inconsistent with its limited and controlled smoking accommodation within medical facilities for long-term-care patients (patients that require a stay in excess of 180 days) since it is an interim measure "that concerns a judgment about patient care and not employee working conditions" (Tr. 138-139, 163-165; Emp. Br. p. 12, 13). These patients make up less than 25 percent of the patient population in VHS&RA medical facilities. Moreover, unlike employees, many of these patients, due to the nature of their infirmity or injury, e.g., chronic psychiatric patients, residents of nursing homes, and spinal cord injuries, are either not ambulatory or the medical facility has essentially become their home. (Tr. 137-138, 163-165, 168.)

24 hours. Consequently, these studies have concluded that smoking is unnecessary for such employees to do their job. (Tr. 43, 89.) Moreover, abstention for 2 or 4 hours (the period between employee breaks) has a **de minimus** effect on their performance level (Tr. 241-242, 245-248, 252, 255; Emp. Exh. 42-44). The Employer will offer medical treatment for the "unusual[ly] severe case" (Tr. 247-248). A smoking ban also would support the efforts of employees who desire to quit smoking on their own or through the Employer's proposed smoking cessation and stress management programs (Tr. 83, 84; FF. Exh. 1(a); Emp. Exh. 11).

The successful implementation of a smoking ban has been demonstrated by the experience of one of the Employer's newer medical facilities, the Minneapolis VA Medical Center,[7/] where DSAs were rejected by a local task force[8/] (Tr. 184, 195, 196, 211). The Minneapolis VA Medical Center accommodates smokers by providing two outside smoking shelters that are constructed adjacent to entrances to the building.[9/] Staffing needs to ensure proper patient care are adjusted accordingly to accommodate employees who have gone out to smoke (FF. Exh. 1(a)).

7/ Minnesota became the first state in the country, in 1988, to pass a law banning smoking in health care facilities by January 1990. The law, however, does not apply to Federally owned facilities. (Tr. 209-210.)

8/ This was a collective effort which included negotiations between representatives from three separate bargaining units (including the local AFGE unit) and local management, and participation by physicians, nurses, social workers, patient educators, experts, and both smoking and non-smoking employees (Tr. 184, 195, 202-203).

9/ Employer's Exhibit 37 provides a detailed description of the structure and accommodations of the outside shelter used by the Minneapolis VA Medical Center. These shelters are intended to provide both employees and patients (including long-term-care patients) protection from the environment, prevention from injury, ventilation, and accommodations so as not to inconvenience the user for its intended purpose (Tr. 188, 193, 194, 203). Employer's Exhibit 34 is a report outlining the Center's experience during its first year of operation under the smoke-free policy in terms of employee and patient reaction and compliance, effectiveness of the outside shelters, the impact on psychiatric and chemical dependent patients, and the effectiveness of the Center's smoking cessation programs.

Finally, ETS is a leading factor in causing "sick building[s]", buildings that generate an inordinate amount of air pollution resulting in increased health problems for occupants (Tr. 86, 105-106, 283-284; Emp. Exh. 12, 22). This issue has received a great deal of attention from unions and management alike in the Federal sector. The Union's proposal is inconsistent with corrective efforts in this regard.

The Union's Position

The Union proposes that the current practice of negotiating smoking policy agreements at the local level, which may include the establishment of DSAs within VHS&RA medical facilities, be maintained (FF. Exh. 1(a)).[10/] It contends that there is an inherent inconsistency in the Employer's smoke-free policy which permits smoking in DSAs within medical facilities by long-term-care patients but bans such practices in acute care areas by all others (Tr. 11, 143-147, 165, 166, 168-169; FF. Exh. 1(a)). Employees, acute-care patients, and the public will continue to come in contact with ETS in those medical facilities that treat or house long-term-care patients (Tr. 167-168). In this regard, the issue does not concern a smoking ban but rather where smoking will be allowed to take place within VHS&RA medical facilities (Tr. 12, 51, 52; Un. Br. p. 1). There have been no significant complaints or reported problems concerning the use or effectiveness of existing DSAs within VHS&RA medical facilities to warrant their elimination as an option in facilities where employees who smoke want them (Tr. 321; Un. Br. p. 3). Furthermore, the Employer "has not established that the[re] [is a] specific standard to identify when the presence of smoke is at a danger[ous] level" (Un. Br. p. 3). Industrial hygienists, whose responsibilities include

10/ The Union makes reference to a recent decision, Department of Health and Human Services, Indian Health Service, Oklahoma City v. Federal Labor Relations Authority, 885 F. 2d 911 (D.C. Cir., 1989) in support of its position (Un. Exh. 3). This decision establishes that proposals on smoking policies "could not be labeled nonnegotiable on the theory that, if implemented, they would directly interfere with the agency's mission and purpose" unless it is found to interfere with an objective for which the agency's technology, methods, and means were adopted. While the decision contains dicta about the merits of the union's proposals therein, the import of the decision is that such proposals are negotiable and thus determinable through the collective-bargaining process. The parties having engaged in such bargaining without success are now properly before the Panel for a resolution on the merits of their respective positions.

"mak[ing] sure that smoking areas are safe", are employed by all VHS&RA medical facilities (Tr. 322).

The continued accreditation of VHS&RA hospitals is not contingent upon achieving smoking bans within the facilities (Tr. 157). Moreover, the Employer has not received reports from such accrediting boards of review that any of the DSAs in any of the Employer's medical facilities presented a problem or prevented the facility from meeting minimum hospital accreditation standards (Tr. 157-160). The Employer also has failed to prove that DSAs have impaired the quality of medical care or that a total smoking ban within VHS&RA medical facilities is the only method of achieving a more healthful environment (Emp. Exh. 17; Un. Br. p. 4).[11/]

With respect to smoking accomodations, the Employer also failed to establish that DSAs, as described by the Employer's Director of Mechanical Engineering, "cannot be developed without [incurring] prohibitive cost" (Tr. 312-314; Emp. Exh. 53; Un. Br. p. 4). As for outside shelters, they are uncomfortable and the ventilation system permits a free exchange of outside air to come in which decreases the effectiveness of the heating system during the colder times of the year (Tr. 203, 345, 360). Moreover, the additional time that would be required to get to these outside shelters and the inaccessibility of an employee while there, relative to DSAs, would have a negative impact on the availability of care for patients (Tr. 349, 355).

Finally, as the exclusive representative of the bargaining unit, the Union must represent the interests of employees that smoke as well as those who do not. In fulfilling this responsibility it has a duty to seek accommodations which treat an employee who smokes as equal to any other employee. (Tr. 353.) In this regard, the Employer's smoking ban within the common workplace discriminates against employees who smoke (Tr. 343). As a general matter, the Union acknowledges the harmful effects of ETS, but believes that through education and over time many will quit, and the last generation that was

---

11/ The Union's latter contention refers to Employer's Exhibit 17 entitled, The Health Effects of Environmental Tobacco Smoke. On page 2 of that article Joseph W. Cullen, Deputy Director, Division of Cancer Prevention and Control, National Cancer Institute, was asked, "Why can't an employer solve the problem by separating smokers from nonsmokers." He responded, in relevant part, "because there is no known threshold for the cancer-causing effect of tobacco smoke, **the only way to guarantee the protection of nonsmokers from ETS is to establish separately ventilated smoking areas** or to make the entire building smoke free." (Emp. Exh. 17.)

encouraged to smoke will die off. Then there can be a smoke-free society. (Tr. 87, 256, 353, 359, 360; Un. Br. p. 1.)

DISCUSSION

It is important to state from the outset that the evidence presented by the Employer concerning the known health risks of ETS is undisputed by the Union. Starting with this premise, an overriding objective is established to secure, to the extent that it is feasible, the health of all employees, patients, and members of the public who frequent VHS&RA medical facilities. Mindful of this objective, what remains to be determined is the most reasonable and practical method of minimizing such health risks while being cognizant of the other interests of the parties. In this regard, while we recognize the Union's obligation to represent smokers as well as nonsmokers, serving the common interest is preeminent when accommodating the respective interests of factions is not mutually compatible.

Turning now to the record and the arguments of the parties, the Union contends that the Employer has failed to establish a definite level or "standard" at which ETS "is at a danger[ous] level." On the contrary, testimony and evidence introduced by the Employer substantiates that a threshold level could not be established at which the health risks created by ETS are eliminated. In other words, there is no minimal level of ETS which is known to be clearly safe.

The Union has focused much attention on the alleged inconsistency in the Employer's smoke-free policy with respect to its limited exception for long-term-care patients. I concur, however, with the Employer's distinction that this exception concerns more of a judgment about patient care than about employee working conditions. Moreover, although employees will be exposed to the ETS generated by this exception, expert witnesses testified at the hearing that the greater the ETS level the greater the risk of developing ETS-related diseases, e.g., lung cancer, heart disease, emphysema. This risk is further aggravated by the multiplier effect for employees who were previously exposed to asbestos and are also exposed to ETS. Thus, the long-term-care-patient exception clearly presents a significantly lower risk than that under a broader exception or the current practice of maintaining employee DSAs.

With respect to whether a practical DSA could be constructed and maintained in any form within VHS&RA medical facilities, the Union asserts that the Employer's Director of Mechanical Engineering gave testimony that a DSA could be developed without incurring prohibitive costs. That estimate, however, was based on the cost of removing most of the uncomfortable aspects of smoking and not to achieve the **de minimus** level of ETS previously noted. Notwithstanding this

limited insulation from the consequences of ETS, it was estimated that it would cost roughly $8,000 to $10,000 to convert ventilation systems in each of the DSAs that did not already have this minimum capability. Whether the cost of such an undertaking would be prohibitive cannot be assessed since it is unknown how many of the ventilation systems in the over 3,000 DSAs would have to be converted. Moreover, although such DSAs may eliminate the unpleasant aspects of smoke, such an approach clearly falls short of eliminating the more insidious consequences of ETS, i.e., health risks. Even assuming the feasibility of creating a separately ventilated smoking area that could "guarantee the protection of nonsmokers", the unrebutted evidence indicates that the expense would not only be excessive to upgrade current ventilation systems in all VHS&RA medical facilities but the result would be to create an impractical environment within a medical facility that was tantamount to a "windstorm." Finally, I note that the Employer's policy which calls for the "[r]eview of scheduling practices so that, where possible, coverage is provided so that staff members may take breaks in order to smoke" provides an affirmative commitment to address the impact of its proposal on employees' patient-care responsibilities.

For these reasons there is insufficient evidence before me, upon careful consideration of the entire record and arguments, to justify the adoption of the Union's proposal. The Union's position is clearly at odds with the weight of the evidence. Accordingly, I recommend that the parties adopt an amended version of the Employer's proposal. Under the recommendation, the Employer would provide a reasonably accessible DSA for employees in each of its medical facilities at which it intends to implement its smoke-free policy. These DSAs should be maintained until such time as the Employer completes construction of reasonably accessible outside smoking shelters at each of its medical facilities to accommodate adequately their intended purpose and the local weather conditions. The Employer should phase in its smoking ban over 90 days or during the construction and completion of the shelter, whichever is longer. Disputes with respect to the adequacy of the shelter, and the accessibility of shelters and interim DSAs would be subject to the negotiated grievance and arbitration procedures. This recommendation is intended to reduce further the presence of ETS that may otherwise be generated by long-term-care patients who may continue to smoke within medical facilities without outside shelters as well as temper the Union's perceived inconsistency in the Employer's proposal in this

regard.[12] I note further that the money the Employer has indicated it would save from the elimination of the DSAs should be more than adequate to finance the construction of outside shelters which it already has "encouraged" local management to provide in its proposed policy.[13]

RECOMMENDATION

The undersigned makes the following recommendation for settlement:

The parties shall adopt the Employer's proposal as modified by its last counterproposal and amended to accommodate and be consistent with the following:

> The Employer shall provide reasonably accessible designated smoking areas (DSA) at each of its medical facilities where the smoke-free policy is implemented. Once these DSAs are established by the Employer, they shall be maintained until such time as the Employer completes construction of reasonably accessible outside smoking shelter(s) at each of the aforementioned medical facilities. The Employer shall phase in its smoke-free policy over 90 days or during the construction and completion of the smoking shelter, whichever is longer.
>
> Disputes with respect to the adequacy of the smoking shelter, and the accessibility of the shelter and

---

12/ This recommendation is not to be interpreted as abridging the Employer's authority to make an exception to its policy at any of its local facilities on an individual basis with respect to long-term-care patients as is the policy at its Minneapolis VA Medical Center (Tr. 193-194).

13/ Accommodating smokers by constructing these outside shelters saved the Minneapolis VA Medical Center the equivalent of the salary of two custodial workers ($52,000/yr) because of reduced cleaning and maintenance requirements (Tr. 204-205; Emp. Exh. 37). Other cost benefits cited by the Employer include the use of additional space for patient care or break lounges -- available to all employees -- as a result of eliminating DSAs (Tr. 21, 186, 212).

interim DSAs are to be submitted to the negotiated grievance and arbitration procedures in the master agreement.14/

Respectfully submitted,

Namsoo M. Dunbar
Factfinder

January 12, 1990
Washington, D.C.

14/ This recommendation is consistent with the recent Panel determination cited by both parties where the Panel acknowleged that it would be inconsistent with the health-care mission of [patient-treating] medical facilities ... to require it to provide designated-smoking areas." In reaching this conclusion, the Panel took into consideration the fact that the employer continued to maintain smoking accommodations outside the facility which "mitigated any inconvenience to employees who continue to smoke." Department of the Army, Fort Riley, Kansas, supra, at p. 2.