Approved 4-6-88
Date

MINUTES OF THE SENATE COMMITTEE ON PUBLIC HEALTH AND WELFARE.

The meeting was called to order by SENATOR ROY M. EHRLICH at
Chairperson

10:00 a.m./p.m. on March 29, 1988 in room 526-S of the Capitol.

All members were present except:

Committee staff present:
Emalene Correll, Legislative Research
Bill Wolff, Legislative Research
Norman Furse, Revisors Office
Clarene Wilms, Committee Secretary

Conferees appearing before the committee:

Dr. Richard Parker, Bureau of Epidemiology, KDHE
Representative Theo Cribbs
Dr. Patricia Schloesser, Director, KDHE
Dr. Roman Hiszczynskyj, Shawnee County Coroner
Verla Britton, Kansas Chapter/National Sudden Infant Death Syndrome Foundation
Debra Wells
Neal Leverenz
Brenda Kehler
Debbie Elwick
Keith Landis, Christian Science Committee on Publication for Kansas
James G. Bridgens, M.D.
Richard J. Morrisey, Director
George Puckett, Kansas Restaurant Association, Wichita
Gary K. Huelett, PHD, Under Secretary, KDHE
Dave Pomeroy, Kansans for NonSmokers Rights
Rev. Richard Taylor, Kansans For Life At Its Best!
Roberta Kunkle, American Lung Association of Kansas

Dr. Richard Parker appeared concerning HB-2978. Dr. Parker stated that the Centers for Disease Control recommended that all health care workers and allied professionals deal with all patients on a "blood and body fluid precaution" basis and because of existing recommendations that universal precautions be pursued, HB-2978 does not appear to be necessary. Therefore, it was not supported in its present form by the Bureau of Epidemiology. Attachment 1

Senator Bond made a motion to amend HB-2978, line 0026 adding HIV or AIDS and on the last page add an immunity section for those who reveal this information. Senator Francisco seconded the motion. The motion carried. Senator Bond stated this amendment would bring the bill language into conformity with SB-686.

Representative Theo Cribbs appeared to introduce HB-2777, better known as the SIDS bill. Representative Cribbs stated that this bill was past due in these days of medical technology. Attachment 2

Dr. Patricia Schloesser appeared in support of the concept of HB-2777. Dr. Schloesser stated some concern about the religious exemptions and proposed expanding Section 2(e) to include the statement "Such religious objection shall not prevent an autopsy from being performed on the legal order of a coroner, or county or district attorney." Dr. Schloesser stated this addition would permit appropriate investigative procedure when an infant death occurs under questionable circumstances. Attachment 3

Dr. Roman Hiszczynskyj appeared concerning HB-2777. Dr. Hiszczynskyj stated objection to Section 1 and the new Section 2 (b) of the bill because the State of Kansas presently has an excellent coroner's law

which, in essence, states the coroner decides whether an autopsy is performed and not the parents or guardians. In the case of a violent or criminal act the parents or guardians could well be the suspects and therefore should not determine whether or not an autopsy should be performed. Further, no religious exemptions should be allowed in a potentially criminal act.

Verla Britton testified in support of HB-2777 stating a mandatory autopsy law for Kansas could mean that, as a nation, we could get closer to discovering the cause or causes of SUDDEN INFANT DEATH SYNDROME and eventually put an end to this silent killer. Attachment 4

Debra Wells appeared in support of HB-2777 stating this is the only way to be absolutely certain of the cause of death. The results of an autopsy could assure parents that the death was not a result of something they or the caregiver did or did not do. and could rule out genetic defects. A second issue would be that the results of an autopsy be made available to the parents in a timely manner. Attachment 5

Neal Leverenz appeared in support of HB-2777 stating that he and his wife had lost an infant and became victims of which county would assume responsibility for an autopsy, and resulted in no autopsy being performed. It was felt that their living children could have benefited knowing if they were at risk from an unknown disease and the parents would know they were not to blame. Attachment 6

Brenda Kehler appeared before the committee in support of HB-2777. Ms. Kehler stated that although she didn't like the idea of autopsies, she now realized the value of them as a part of grieving, family planning and research value. Therefore, Ms. Kehler supports the addition of this section to the current autopsy law which the Kansas Department of Health is proposing. Attachment 7

Debbie Elwick appeared in support of HB-2777, stating she was the parent of a SIDS infant. Since the existing law permits the coroner to waive autopsy for suspected SIDS victims, it effectively establishes a road block to obtaining possible facts concerning this syndrome. Ms. Elwick stated that she was aware waived autopsies saved monies in small counties but the lack of autopsy creates its own set of problems. Attachment 8

Keith Landis spoke briefly stating that the religious exemption included in HB-2777 should not be attributed to him or his organization, also that he was unaware of its origin.

Dr. James G. Bridgens appeared concerning HB-2777 and offered suggestions for consideration. Changes suggested include changing "coroner" to "law enforcement officers", line 0048; deletion of new Section 2(c) and payment for SIDS autopsies be made as provided by KSA 19-1033 under which the county in which the "cause of death occurred" pays for the services; Section 2(e) providing for religious belief objection should be deleted. Dr. Bridgens also stated he felt a provision for SIDS deaths to be reported to local SIDS support group or county health departments would be helpful. Attachment 9

Richard J. Morrissey appeared in support of HB-3075 stating this bill would allow children and adults to receive day care services in separate areas of the same premise and share those activities that are mutually beneficial. Attachment 10

Senator Bond moved to pass out HB-3075 favorable for passage and request it be placed on the consent calendar. Senator Francisco seconded the motion and the motion carried.

George Puckett, Kansas Restuarant Association appeared in opposition to HB-2717 stating that in its amended form this bill is discriminatory

against restaurant owners. The original bill stated "public place." Mr. Puckett further stated that the Kansas Restaurant Association continues to oppose proposed government mandated percentages regarding smoking sections. The restaurant owner has been singled out from other public places to be made an example of on the matter of smoking in public. Other public buildings would not be required to comply with the same mandated percentage of smoking area that restaurant operators would be forced to contend with if this unfair measure were allowed to become law. Attachment 11

Gary Huelett testified in support of HB-2717 because it would help protect the non-smoker from the involuntary health consequences of exposure to tobacco smoke in public places. Attachment 12

Dave Pomeroy testified in support of HB-2717 stating his disappointment that the bill had been amended to include only restaurants instead of all public places in the state. Mr. Pomeroy made reference to the federal law which will soon ban smoking on flights under two hours in length. Mr. Pomeroy further commented on the Surgeon General's Report on Smoking which states there is no safe level of exposure to tobacco smoke. Attachment 13

Rev. Richard Taylor appeared before the committee in support of HB-2717. Rev. Taylor told the committee this bill was amended by committee and then failed on the House floor. Later, on General Orders a compromise was presented that states "the total area of all designated smoking areas in any public place shall not exceed 50% of the total area of the public place." Rev. Taylor also related his own personal experience with cancer of the vocal cord which could have been related to second-hand smoke. Attachment 14

Roberta Kunkle, speaking for the American Lung Association, stated that the original intent of HB-2717 was to clarify HB-2412 which was passed during the 1987 legislative session. A ruling by the Attorney General that proprietors were free to designate their entire buildings as smoking zones followed thus necessitating clarification of original intent. Attachment 15

The chairman placed the minutes of March 21, 22, 23, 24 and 25 before the committee for approval or correction.

Senator Morris made a motion to approve the minutes as presented. Senator Francisco seconded the motion and the motion carried.

Senator Bond made a motion to send HB-2978 to Ways and Means Committee. Senator Francisco seconded the motion and the motion carried

Senator Francisco acknowledged the educational efforts of the American Lung Association of Kansas.

The meeting adjourned at 11:05 a.m. and will meet at 12:00 noon tomorrow, Wednesday, March 30, 1988 in room 526-S.

SENATE
PUBLIC HEALTH AND WELFARE COMMITTEE
DATE March 29, 1988

(PLEASE PRINT) NAME AND ADDRESS		ORGANIZATION
Robert L. Swain - Dodge City		Ks. Fam'l Directors
Jim Snyder	Topeka	KFDA
Larry K. McElwain	Lawrence, Ks.	KFDA
Dick Taylor	Topeka	Life at its best!
Harold Potts	Topeka	KCOA
Allyn O. Jackson	"	SRS
Keith Welbir		Gov Staff
Barbara Snider	"	Pete McGill Assn.
Rita Kay Ryan	Topeka	KDHE
Jim Heidebrecht	Topeka	KDHE
Debra Wells	Fredonia	SIDS
Stephanie Mellon	Fredonia	
Collin Mellon	Fredonia	
Lisa Wells	Fredonia	
Roberta Kunkle	Topeka	American Lung Association of Ks
Dave Pomeroy	Topeka	Kansans for Non Smokers Rights
Sheila Britton	Norton, Ks	President Ks. Sudden Infant Death Syndrome Chapter
Neil Lovering	Wichita, Ks	Board Member of S.I.D.S.
Debbie Mueck	Salina	S.I.D.S.

SENATE
PUBLIC HEALTH AND WELFARE COMMITTEE

DATE 3-29-88

(PLEASE PRINT) NAME AND ADDRESS		ORGANIZATION
Carolyn Mossendorf	Topeka	KSNA
Norma Daniels		Sen. Jan
Brenda Kuhlman		
JOE A. MORRIS		KANSAS LEAGUE OF SAVINGS INST.
Bob Williams		KS. Pharmacists Assoc.
Lori Edwards		Washburn Nursing Student
ROMAN HISZCZYNSKYJ, MD		District Coroner, Shawnee County
James G. Bridgens, M.D.		Concerned Public
		KDHE
Lon Bahr	Topeka	L. Statistics Dept.
KEITH R. LANDIS	"	CHAIRMAN SCIENCE COMMITTEE ON PUBLICATION FOR KANSAS
G.K. Hulett	Topeka	KDHE
Richard Morrissey	"	KDHE
R.L. PARKER	"	KDHE
Terri Roberts	Topeka	Kansas State Nurses' Assoc.

STATE OF KANSAS

DEPARTMENT OF HEALTH AND ENVIRONMENT
Forbes Field
Topeka, Kansas 66620-0001
Phone (913) 296-1500

Mike Hayden, *Governor*

Stanley C. Grant, Ph.D., *Secretary*
Gary K. Hulett, Ph.D., *Under Secretary*

Testimony Presented to

Senate Committee on Public Health and Welfare

by

Kansas Department of Health and Environment

House Bill 2978

House Bill 2978 would require the physician attending a person who dies of an infectious or contagious disease to provide written notification describing the disease to the transporter of the body or to the embalmer or funeral director. If a person dies of an infectious or contagious disease outside of a medical facility a family member or other person making arrangements for disposition of the body must notify in writing the person transporting the body of the diagnosis. The transporter of such a body must also notify the embalmers or funeral director.

There have been 117 cases of AIDS reported through January, 1988 in the State of Kansas. It is estimated that as many as 50 persons are infected with the human immunodeficiency virus (HIV) for every case of AIDS reported, but most of these are not ill and therefore not known. In addition many people are infected with hepatitis B virus or other blood-borne infectious agents which may not be producing recognizable illness at a given moment. All of these, should they die of any other cause, could be of as great or even greater threat to those handling the body than a person directly dying of the disease resulting from the infection.

Section 1(d) would require maintenance of confidentiality. However, it is questionable whether or not persons in contact with bodies need to know the exact cause of death since the precautions would be the same for all blood-borne diseases, all respiratory diseases, etc. It would be possible to develop a list of diseases potentially dangerous to those providing post mortem

services and a system to advise that appropriate precautions be taken when the listed diseases were involved.

The Centers for Disease Control have recommended* that all health care workers and allied professionals deal with all patients on a "blood and body fluid precaution" basis, e.g., everyone should be regarded as a potential source of blood borne infectious agents. Morticians and others providing post mortem services for a body are included in the recommendations.

Because of existing recommendations that universal precautions be pursued, H.B. 2978 does not appear to be necessary. It is therefore not supported in its present form.

*Recommendations for Prevention of HIV Transmission in Health-Care Settings. MMWR Supplement Vol. 36, No. 25 Aug 21, 1987.

Presented by:

Richard L. Parker, DVM, MPH
Director
Bureau of Epidemiology
March 29, 1988

STATE OF KANSAS

THEO CRIBBS
SEDGWICK COUNTY
1551 NORTH MINNESOTA
WICHITA, KANSAS 67214

TOPEKA

HOUSE OF
REPRESENTATIVES

COMMITTEE ASSIGNMENTS
MEMBER: PUBLIC HEALTH AND WELFARE
CONSERVATION AND NATURAL
RESOURCES

March 29, 1988

TO: Senate Public Health & Welfare Committee
FROM: Representative Theo Cribbs

Mr. Chairman, Vice Chairman and members of this very lustrous committee. My name is Theo Cribbs and I appear before you this morning on behalf of HB 2777, known as the SID's Bill, which means Sudden Infant Death Syndrome. Instead of a testimony, I am including some facts about SIDs taken from a brochure from the National Sudden Infant Death Syndrome Foundation, which I will read to you at this time.

THE BASIC FACTS ABOUT SIDS

- SIDS is the number one cause of death in infants after the first week of life.
- SIDS is not a rare disease. About 6,000 to 7,000 babies die of SIDS every year in the United States (about two per 1,000 live births).
- SIDS most commonly occurs to infants between the ages of three weeks and seven months, but occasionally an older or younger baby may die of SIDS.
- There is no suffering; death occurs within seconds, usually during sleep.
- SIDS is at least as old as the Old Testament and seems to have been at least as common in the 18th and 19th centuries as it is now. Often referred to as "crib death," the term Sudden Infant Death Syndrome (SIDS) came into general medical use after 1969.
- The cause is not suffocation, aspiration or regurgitation, although sometimes death certificates bear such terms in error. SIDS became an acceptable term for general use on death certificates after 1973, and periodically other terms may still be employed.

- A minor illness such as a common cold may precede the death, but many victims display no observable symptoms. The majority have appeared to be entirely healthy.
- SIDS is not contagious in the usual sense. Although a viral infection may be involved, it is not a "killer virus" that threatens other family members or neighbors.
- SIDS is not considered hereditary.
- SIDS occurs among families of all social and economic strata.
- Researchers believe that SIDS probably has more than one cause although the final process of death may be similar in most instances.
- Because of the nature of SIDS, no single test has been discovered to identify which infants will succumb to it; therefore, there is no general means of prevention.

NATIONAL SUDDEN INFANT DEATH SYNDROME FOUNDATION

Mr. Chairman, this is a bill that is way past due in this modern time of medical technology. I hope you will pass this bill favorably, thank you for your consideration and time.

THEO CRIBBS
State Representative
District #89

STATE OF KANSAS

DEPARTMENT OF HEALTH AND ENVIRONMENT
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Testimony Presented to

Senate Public Health and Welfare Committee

by

The Kansas Department of Health and Environment

House Bill 2777

Perhaps the most tragic of all infant deaths occur when an infant dies under circumstances in which death was not anticipated, or occurs from no apparent cause. In this situation, grief is a particularly intense, lonely, and personal experience. When a child dies suddenly and unexpectedly, not only does the death destroy dreams and hopes for the child, but it forces the family to face an event for which they were totally unprepared.

Infant death, defined as death of a liveborn infant within the first year of life, is a public health issue. Legislation enacted in 1915 requires the Kansas Department of Health and Environment to study the causes of infant deaths and apply measures to prevent these deaths. Accurate reporting of the cause of death, based on an autopsy, facilitates the identification of public health strategies designed to reduce the incidence of such unanticipated deaths.

Although this bill, as amended, does not specifically reference Sudden Infant Death Syndrome (SIDS), it is one circumstance in which unanticipated infant death occurs. In Kansas, there have been an average of 56 SIDS deaths per year for the past five years, with an autopsy rate of 75%. An additional 10-15 deaths per year have occurred in which SIDS along with a more specific cause of death has been listed on the death certificate. For vital statistic purposes, these have not been considered SIDS deaths. Under the provisions of this bill an autopsy would be ordered in these cases.

We would recommend expanding Section 2 (e) of HB 2777 to include the statement, "Such religious objection shall not prevent an autopsy from being performed on the legal order of a coroner, or county or district attorney." This expansion is recommended to permit appropriate investigative procedure when an infant death occurs under questionable circumstances.

Although this proposal was not contained in the Governor's FY 1989 budget, we support the concept of this legislation.

Presented by:

Patricia T. Schloesser, MD
March 29, 1988

KANSAS CHAPTER/NATIONAL SUDDEN INFANT DEATH SYNDROME FOUNDATION
RR 2 NORTON KS 67654 [illegible]

February 25, 1988

Like many things in todays world, when it comes to Sudden Infant Death Syndrome and the impact this entity has on the family and the community it doesn't just effect those intimately involved, it affects society as a whole.

This can happen when others around the family question their worth as loving and protective parents. As parents we are taught to protect our young from all dangers but how can we protect a content and sleeping infant from something we can't see, or hear and has no warning symptoms? The one and only symptom is death.

The parents suffer by their own "If's" enough without the worry of being suspected of child abuse or neglect--by well meaning family, friends, or acquaintances. Without the benefit of an autopsy, they have nothing with which to console themselves or others. No final findings to base the decision of having a subsequent child in the years ahead, should they make that choice.

A mandatory autopsy law for Kansas could mean that as a nation, we could get closer to discovering the cause or causes of SUDDEN INFANT DEATH SYNDROME and eventually put an end to this silent killer. But most of allit would stop the destruction it leaves in it's path when it strikes a sleeping infant at random.

Verla Britton, President

MANDATORY AUTOPSY

Testimony

by

Debra Wells

Senate Public Health & Welfare
March 29, 1988
Attachment 5

Friday, May 16, 1980 began like any other day. The baby was up at 5:30 a. m. for his bottle and a diaper change. After our morning quiet time, he sat in his swing while I readied myself for work. (I had returned to my teaching position just the week before to close out the school year so I could devote myself to being a full-time wife and the mother of a newborn son and an 18 month old daughter.) Just a few more days, I thought to myself that morning. Before I left the house at 7:00 a. m., I remember kissing my son and sharing my thoughts aloud. Just a few more days . . . .

Those were the last words my son heard from his mother. At 2:30 that afternoon, I received a call at school. My son had been rushed to the hospital. The 20 minute drive to the hospital was the longest of my life. What possibly could have happened to my beautiful baby boy?

Upon arrival at the hospital, I was escorted to a private room. Within a matter of moments, the circumstances and tragic consequences of an afternoon nap were made all too clear. Our baby had died suddenly and unexpectedly.

After telling us of our son's death, our family physician asked us if we wanted an autopsy. Our son had suffered enough; nothing would bring him back. We declined the autopsy. (It is important that you understand our ignorance of autopsies and our gross misconception of what would be done to our child if an autopsy were performed. No one explained either the need for or the manner in which an autopsy is done.)

We were given some private moments with our son in one of the hospital's emergency examining rooms. After our final good-bye, we returned to the private room we had been given only to be told that our son's death was being classified as a coroner's case. An autopsy was mandatory in all cases such as this. The decision for autopsy was out of our hands. We received no explanation and were given no opportunity to ask any questions.

I now know the necessity of an autopsy. And had I known then what I know now, I would have agreed to the autopsy. I also believe if someone had told us why it was an important that an autopsy be performed, we would have understood. But to throw the words "coroner's case" at us without any explanation caused us a great deal of agony. What had happened? What did they suspect?

In mandating autopsy, it will be very important that parents be told the need for an autopsy. They must be reassured of the compassion and delicacy with which it is performed. In the great majority of cases of sudden and unexpected death, the parents (or care-givers) must be above suspicion. Autopsy will identify without doubt a cause of death. If, upon autopsy, their is reason for suspicion, the case can be handled accordingly.

I fully support mandatory autopsy legislation for all cases of sudden, unexpected death in infants. The only way to be absolutely certain of the cause of death is through autopsy. The results can assure parents that their child was not a victim of neglect or abuse; that his death was not a result of something they, or a care-giver, did or did not do. It can rule out the possibility of genetic defects that might be passed on to subsequent children. A diagnosis from autopsy gives parents a cause of death, a reason to explain and attempt to understand the tragedy.

A second issue of equal importance is that autopsy results be made available to the parents within a timely manner. Everyone the parents encounter wants to know what happened to the baby. Parents need educated answers, not guesses. Until they have the autopsy results, neither they, nor anyone else, can be certain why the baby died.

It took me over six weeks to find out why my baby died. I made several phone calls in the days and weeks following his death and was either referred to another number or told I would have to wait until the autopsy results became a matter of public record. For six weeks I hung on to the words "sudden infant death syndrome". Our physician had mentioned SIDS as a possible cause of death in the emergency room. And even though we had a possible cause, somehow, knowing that an autopsy had been performed, I was desperate to see in writing or hear from a qualified source, why my baby died. Without persistence, I would never have had the answers I needed. After several calls to the County Clerk's office over a matter of several weeks, I finally learned the autopsy results were on file. I drove to the Clerk's office, identified myself as the mother of the victim and paid 25¢ per page for a copy of the autopsy results. My baby had died in May and it was July before I knew why.

Unfortunately, despite the frustration of my situation, I am one of the lucky ones. There are many parents in the State of Kansas who never know why their baby died. They either did not have an autopsy performed and someone is "guessing" why their baby died or they did not have the stamina and persistence in a weak emotional state to fight the red tape it took for me to get the answers I so desperately needed.

It is very important that upon completion of the autopsy, a qualified medical professional convey the results to the parents. He will be able to answer any questions they may have surrounding the death and he can reassure them that the cause of death is definitive. Parents have a need to know. I belive they should also have the right to know why their babies are dying. By

mandating autopsy legislation and requiring that the information be given to the parents as it becomes available, the State of Kansas will join the many other states nationwide who have recognized the need for this important piece of legislation.

Thank you for taking this proposal into consideration.

Debra Wells

Debra Wells

SUDDEN INFANT DEATH

I want to thank you all for giving us this chance to speak on the behalf of the Sudden Infant Death Syndrome Foundation, concerning mandatory autopsy laws for the state of Kansas.

My wife and I lost our child Jason on the 25th of January 1986. He was 3 months old. At that time we resided in Rose Hill, Kansas, Butler County, a suburban of Wichita, Ks.

Jason was found by myself at 8:00 am. I immediatly called 911. The Emergency Medical Techanicians arrived at our home immediately and performed all necessary measures to save our son . They decided to transport Jason to Wesley Hospital which is located in Wichita, Kansas, Sedgwick County.

The ambulance which was transporting Jason from Rose Hill was met outside of Butler county by a pediatric ambulance, out of Wesly hospital. Jason was transferred to this pediatric care unit and rushed to wesly.

At 9:30 am, Jason was pronounced dead. At this time hospital personel informed me that an autopsy would be performed. At 12:30 pm as my wife and I were leaving the hospital a nurse ran after us and told us that the doctor had changed his mind and decided not to do an autopsy, and if we wanted one it was our choice.

Why was it our choice on wheather to go ahead and let them perform an autopsy. Because Butler county was responsible for payment, Jason was prononced dead in Sedgwick county, but died in Butler county. The Sedgwick county coroner said Sedgwick county was not responsible for payment so before an autopsy was performed in Sedwick county, Butler county coroner had to okay it.

Was it okayed? Butler county told us they okayed the autopsy, Sedgwick county denies this claim. If there was a mandatory autopsy law, this type of mis-understandings would not take place. So who's court is the ball in now, two hysterical parents, being my wife and I. From our own experience this is not a time for anyone to be making a critical decision. You have just had your whole life shatterd. In the end my wife and I were really confused and chose not to have an autopsy performed.

How do we feel now? Regretful. I know deep down inside we will never know what took our sons life. If I want to belive the doctors experience in Sudden Infant Death I would belive he doesn't really know himself. If I was to ask the doctor to swear before me & God that he knew for a fact that SIDS is what Jason died of, he could not answer yes. But, He could of answered yes if an autopsy had been performed. The doctor would have known, and we as parents would have known.

Lets look at the cause of Jasons death being, not that of SIDS. Any futher childern we decide to bear could be at a greater risk of an unkown disease. Our living children we now have could be at a risk of an unknown disease to us.

Sure, Jason was a healthy 13lb baby boy when he died, and he had all the charateristics of a SIDS baby, or as they say the tell tail signs. No one will absolutely know for sure without an autopsy.

I really believe that in the long run parents, doctors, family will feel more at ease with an autopsy, taking uncertainty and guilt away from all. Let me elaborate on the guilt; parents, grandparents and medical personel could and do feel,the majority of deaths have known causes. Reasons for the death. A SIDS baby has no known cause. Which leaves the parents to blame themselves.

My wife remembers wondering and questioning herself on what she did wrong to cause Jason to die? What did she eat? What could she have done to prevent this death? What did she do to cause this harm to her baby. We had no one or no disease to blame for our sons death. So who does one turn to, yourself. We had two previous children to Jason. In this day an age she was considered a pro by all her collegues, on child rearing. Sure we were told Jason died of SIDS and there is a part of us that believes that is what he died of. But know-one will really ever know. And, believe me it is a very empty and sometimes scary feeling we will carry with us for the rest of our life.

I am very thankful to the SIDS organization for the support they have given us in the last two years. And, we have learned to except Jasons death. But looking back at the last two years I can think of many times being asked if Jason had an autopsy and being ashamed to answer no, wishing I could answer yes.

Beleive me no young couple wants to think of their baby being autopsyed after they loose them so suddenly. But I cannot think of one couple whose ever regretted having to have an autosy as much as we have regretted not having one.

Thank you.

March 28, 1988

Brenda Kehler
4261 N.W Fielding
Topeka, Ks. 66618
913-286-1235 Home
913-273-7010 Work

Last year, on Feb. 4 I gave birth to my second child. Christopher was a beautiful healthy 7 pound 10 ounce full term baby. On April 22 while he was taking his afternoon nap he stopped breathing. At Stormont-Vail Emergency Room the doctors revived his heart after two hours of CPR. On April 23 Chris turned 11 weeks old. On April 24 he was officially pronounced dead. He had all the classic symptoms of Sudden Infant Death Syndrome (SIDS). His death certificate says the primary cause of death was aborted SIDS, the secondary cause was cardiac arrest, but that might not be true.

Before Chris was really dead the Doctor said that an autopsy might need to be done. My husbands and my reaction was not very positive, we did not want "that" done to our son. But we were only thinking of the situation at that moment. The subject of autopsies was never brought up again and we did not have one performed. Since then, there have been times that my husband and me wondered if there was something else that killed Chris but now we will never know. As of last week, it has been 11 months since Chris died and we are trying to have another baby and we wish we knew if Chris really died of SIDS or if it was something else. If we had an autopsy performed we would have a better idea if our next child is at risk of the same thing.

I'm like most other people, I don't like the thought of autopsies. But now, I realize the value of autopsies as a part of greiving, family planning and the research value that they have. It is because of those three reasons that I support the addition of this section to the current autopsy law. I also support the changes that the Kansas Department of Health is proposing.

Senate Public Health & Welfare
March 29, 1988
Attachment 7

TESTIMONY CONCERNING
MANDATORY AUTOPSY LAW
FEBRUARY 25, 1988

Debbie Glick

As are several of the others here this afternoon, I am the parent of a SIDS victim. Her name is Annie. She would have been seven years old next month. However, I am also here as a former RN who, ironically, specialized in the care of the sick and/or premature infant. I have lost my daughter and some of my patients to Sudden Infant Death Syndrome. And it is my belief that the significance of the legislation that we are proposing is even more understandable when we keep both of these perspectives in mind.

This generation has grown accustomed to raising its children to adulthood. And, there is good reason for that attitude. I have been privileged to witness for myself the explosion of knowledge and technology that has improved the odds for the premature or sick infant that is born in this day and age. Babies that yesterday wouldn't have had much of a chance for survival, are now not only doing so, but most are looking forward to a creative and sustantive life. I was, and still am proud of the work that was being done in that nursery. And, one of the happiest parts of my job was to send home an infant that had "beaten the odds". And, we were careful to tell the parents what to look for in the care of their child. We would say things like, "Keep your baby out of crowds for the first few weeks. Be sure to feed your baby every three hours until they have achieved a certain weight gain. Elevate the head of their crib if they develop a runny nose or other cold symtoms and

then call your doctor." But we had nothing to tell them to prevent their child from dying of SIDS. And some of them did. When that happened, I would always feel a little bit of guilt, wondering if there had been something that I could have said or done that would have made a difference in the baby's outcome. But, more than guilt, I would feel an overwhelming sense of frustration. In particular, I remember two patients that we had worked on for over two months. Over two months, only to have some syndrome whose pathology we can neither trace nor predict, wipe out all of that work in seconds.

One afternoon, after giving a lecture on SIDS, I spoke to a young family practice resident. Sadly, the very first baby that he delivered died of SIDS. He voiced his frustration this way, "I would have done everything that it was in my power to do, if only I had known that I was supposed to be doing something. I examined that child several times. I would have sworn that she was healthy." His words speak eloquently to the frustration and bewilderment that the medical community feels about this syndrome. Those words echo my own frustration and guilt over my daughter's death, as well. The truth of the matter is that, though there is much that pediatric medicine can do for the sick or premature infant born today, there is a select number of normal, healthy-looking infants for which we have no answers.

What we know about SIDS sounds more like the MO for a cat-burglar than it does for a medical syndrome. We know that SIDS is quiet, overtaking its victims while they are asleep in their cribs. We know that it strikes randomly, selecting its victims from every race and socio-

economic circumstance. We know that it happens most frequently where parents feel safest about their children, the home. And, finally, we know that we cannot predict when or where it will strike next.

We do not now have many answers for me, or other SIDS parents like me as to why our children died. But, we are learning. And, a good deal of what we are learning is gleaned from autopsies. It is not an easy way to learn. Autopsy is not the fate that I would have picked for my Annie. But, when the one and only symtom is death, then autopsy is the only way that SIDS can be studied under the actual circumstances.

Unfortunately, with the law in existance, autopsy can be waived when the coroner suspects SIDS. Believe me, I understand the motivation to waive autopsy for suspected SIDS victims was one of compassion and sensitivity for the parents involved. And, it is not just from the medical standpoint that I favor adopting this mandatory autopsy law. It is also for the parents that I am concerned. I can say with all candor that I am glad that an autopsy was performed on our Annie. For, in the dark hours of my grief, I could, by virtue of the information on Annie's autopsy, reassure myself that their was no hidden abnormality that took my daughter's life. There is nothing that I, as a nurse and mother, could have done to save her. And, when our next child was on the way, I could remind myself that there had been nothing genetically wrong with Annie that could be passed on to the new baby.

This legislation is important, too, because we need to insure that SIDS is called SIDS. It is not virulent pneumonia or sudden cardiac failure. Nor is it possible suffocation or regurgitation. The only thing

that those terms do is serve to create further grief on the part of the parents because they insinuate that there was something about our baby that could have been observed and treated. We are already overburdened with guilt over losing what seemed to be a healthy baby. It would be an act of kindness for the state of Kansas to see to it that the results of an autopsy don't add to the guilt. SIDS is SIDS. It is neither predictable nor preventable. The fact that there are times when doctors choose to call it something else on an autopsy is, I believe, the doctor's frustration in not finding anything else there to diagnose. If we as a generation find it difficult to accept the fact that seemingly normal infants die for no apparent reason, then we should be able to understand that doctors are no different. They may intellectually come to terms with the facts, but they still have a basic impulse, like the rest of us, to assess responsibility to something. Hence, the need for using terms other than SIDS. And, when other terms are used, then valuable information is lost. And that makes studying data that much more slow and difficult.

At this time, the counties now pay for autopsies. For larger counties this is not as much a travesty as it is for the smaller ones where the funds are not very large. As the law now stands, it is possible for the coroner to assume that the cause of death is SIDS and waive the autopsy. In doing so, he does save the county the cost of a post-mortem, but the lack of an autopsy creates its own set of problems to which I have already spoken. In the end, an autopsy is an act of compassion for the parents of SIDS victims and means to answers on behalf of all future babies and their parents.

Annie's death left a grieving mother and father, as well as grandparents, aunts, uncles, friends, neighbors, and an older sister. If she had lived, Annie would have had two younger brothers. And all of us desparately want to know why she died. This same scenario will be played out approximately 75 times across the state this year. Add that to the number of children who have died in years prior, and one can begin to understand the significance of this piece of legislation. It is my prayer, indeed, my firm belief, that by passing this mandatory autopsy law, we will speed the day when the SIDS parents in this room will know how their baby died and how we can keep other babies from dying because of this untraceable and unprdictable syndrome. I think that I speak for every SIDS parent in this room when I say that we already know what it is like to be SIDS parents. We don't want to know what it is like to be SIDS grandparents!

DATE: 29 Mar 88

TO: Senate Public Health and Welfare Committee

RE: House Bill No. 2777

FROM: James G. Bridgens, M. D.

The proposed changes in the Coroner's Law effected by this House Bill constitute a significant improvement over the existing law.

A few suggested changes are offered for consideration:

Line 0048--change "coroner to "law enforcement officers", as the police usually have initial contact with the parents or guardian. The coroner usually does not have immediate involvement with the parents.

Section 2, (c) authorizes payment of the pathologist by the Department of Health and Welfare (DHW). This presents two methods of payment for the autopsy--all, except SIDS cases, will be paid by the county; SIDS cases will be paid by the DHW. It is preferable that all be handled the same.

In 1986 there were 69 cases of SIDS reported to vital statistics for an incidence of 1.46/1000 live births. The national average of SIDS cases is 2/1000. Thus, about 25% of the cases are currently missed. Of those so diagnosed, 75% have been subjected to an autopsy. Potentially, there are about 17 that are not autopsied and an additional 20 that are slipping through the cracks. This gives an estimated additional 37 cases that are not currently evaluated by autopsy.

Those cases that are now autopsied undoubtedly occur in the most populous counties. The remaining 37 are scattered over approximately 100 counties with an estimated annual cost of less than $37,000. It would seem inappropriate to transfer the payment for all SIDS cases to DHW.

I would urge that paragraph (c) of New Sect. 2 be deleted and the the payment for SIDS autopsies be made as provided by KSA 19-1033 under which the county in which the "cause of death occurred" pays for these services.

Section (e) providing for objections to the autopsy based on religious beliefs should be deleted. It contradicts Section I of the proposed (and existing) KSA 19-1031. The addition of this section can create nothing but legal disputes as it identifies and treats SIDS cases differently from all other deaths that come to the attention of the coroner. Moreover, who is going to define "a recognized church or religious denomination?" The problems created by this section will emasculate the coroner's law and form the basis of problems beyond imagination. The current statute appears to be

working very well, why create problems?

Because of the intense emotional impact on the parents, it is appropriate that some outside help be available. I would urge that provides for SIDS deaths be reported to the local SIDS support group or the county health department. Such additional requirements should be added to the current bill.

Thank you for the opportunity to present these items to the committee for consideration.

STATE OF KANSAS

DEPARTMENT OF HEALTH AND ENVIRONMENT
Forbes Field
Topeka, Kansas 66620-0001
Phone (913) 296-1500

Mike Hayden, *Governor*

Stanley C. Grant, Ph.D., *Secretary*
Gary K. Hulett, Ph.D., *Under Secretary*

Testimony Presented to

Senate Committee on Public Health and Welfare

by

The Kansas Department of Health and Environment

House Bill 3075

Background

Currently, 65-510 makes it unlawful for any home to receive or care for any aged or indigent adult. The need for child day care services is well documented. Increasingly, adults are having to worry about caring for their parents. Intergenerational day care is one solution for both problems.

This legislation would allow children and adults to receive day care services in separate areas of the same premise and share those activities that are mutually beneficial.

The amendment of K.S.A. 65-510 will allow for the creation and operation of services vital to children, adults and families of Kansas.

Examples

There are two adult care homes in Kansas operating licensed child care centers. Child care is provided in facilities separate from adult facilities. Under the current law, children and adults cannot share any activity. Structured, shared activities could provide a worthwhile mix of the generations which is often not possible in today's families. Children would have the opportunity to enjoy and learn from grandparent figures. Contact with children would provide a sense of worth for adults.

Office Location: Landon State Office Building, 900 S.W. Jackson

The Green House Intergenerational Day Care Center to be constructed in Topeka would be prohibited from providing programs that mix the generations. Services proposed for the Green House have been well planned and should serve as a model for future intergenerational day care centers in the state.

Recommendation

We support passage of this bill.

Presented by: Richard J. Morrissey, Director
Bureau of Adult and Child Care
March 29, 1988

KANSAS RESTAURANT ASSOCIATION

359 SOUTH HYDRAULIC • P.O. BOX 235 • WICHITA, KANSAS 67201 • (316) 267-8383

My name is George Puckett, and I represent the Kansas Restaurant Association, a statewide group of owners and managers representing the Kansas foodservice and hospitality industry. The KRA opposes HB 2717, and its proposed government mandated percentages regarding smoking sections.

HB 2717, as amended has, in our opinion, actually deteriorated to the point of discrimination against restaurant operators, from its original form. Notice specifically that the words "public place" has for some reason been deleted in lines 0050 and 0052, and the word "restaurant" has been inserted in place of these words. The restaurant operator has been singled out from other public buildings to be made an example of on the matter of smoking in public. Other public buildings, as amended, would not be required to comply with the same mandated percentage of smoking area that restaurant operators would be forced to contend with, if this unfair measure were allowed to become law.

KRA continues to maintain the position that, professional operators will and must provide adequate smoking and non-smoking areas for customers, just as they must provide good food and service, or the customer does not return to that restaurant. Consequently, operators should be allowed the continuing respect of seating restaurant customers and meeting their individual needs with each different group that dines in that facility. Laws are not capable of determining the individual needs of the customers in a restaurant at any given meal. Sometimes more than 50% is needed for non-smokers, which this bill would allow. Other times more than 50% is needed for smokers, which this measure does not allow. I personally do not smoke, but is it fair to a smoker to be refused seating because he or she smokes and the non-smoking section is at 50% maximum capacity? Is it fair to the operator with customers waiting but only the wrong kind of seating is available, who many times leave and go someplace quicker? The loss of business resulting from this type of mandated law could very well put some operators out of business who are currently running on a tight profit margin.

A very disturbing fact about HB 2717, and very surprising to Kansas foodservice operators, is the manner in which this measure was so suddenly amended before the full House to apply only to restaurants, and no other buildings regarding government regulated smoking areas. Kansas restaurant operators deserve protection from this type of unequal legislation. Greater efforts must be taken to insure that future legislation regarding smoking, or any matter pertaining to public buildings, must be consistent, fair, and written in an equitable manner.

Senate Public Health & Welfare
March 29, 1988
Attachment 11

STATE OF KANSAS

DEPARTMENT OF HEALTH AND ENVIRONMENT
Forbes Field
Topeka, Kansas 66620-0001
Phone (913) 296-1500

Mike Hayden, *Governor*

Stanley C. Grant, Ph.D., *Secretary*
Gary K. Hulett, Ph.D., *Under Secretary*

Testimony Presented to
Senate Public Health and Welfare Committee

by

The Kansas Department of Health and Environment

HOUSE BILL 2717

This bill concerns smoking in public places and gives the proprietor authority to establish the percentage of area that will be designated as a smoking area. However, in restaurants that have more than 1,000 square feet, smoking areas can not exceed 50% of the total area of the restaurant.

The detrimental health hazards of second hand tobacco smoke is well documented. A 1986 report of the Surgeon General entitled, "The Health Consequences of Involuntary Smoking" examines the evidence that even a low exposure to smoke received by the non-smoker carries with it a health risk. This report makes the following conclusions:

1. Involuntary smoking is a cause of disease, including lung cancer, in healthy non-smokers.

2. Simple separation of smokers and non-smokers within the same air space may reduce, but does not eliminate, exposure of non-smokers to environmental tobacco smoke.

3. The children of parents who smoke, compared with the children of non-smoking parents, have an increased frequency of respiratory infections, increased respiratory symptoms, and slightly smaller rates of increase in lung function as the lung matures.

A 1986 article in the British Medical Journal entitled, "Does Breathing Other People's Tobacco Smoke Cause Lung Cancer?" reviewed data from 13 epidemiological studies of lung cancer and exposure to other people's smoke. It found that non-smokers living with smokers have a 35 percent increase in the risk of lung cancer compared with non-smokers who live with non-smokers. This analysis supports the conclusion that breathing other people's tobacco smoke causes lung cancer.

We support the bill because it would help protect the non-smoker from the involuntary health consequences of exposure to tobacco smoke in public places.

Presented by:

Gary K. Hulett, Ph.D.
Under Secretary

March 29, 1988

Kansans for
NonSmokers
Rights

P.O. Box 204 Topeka, Kansas 66601-0204

Statement by Dave Pomeroy March 28, 1988

When House Bill 2717 was revised to include only restaurants instead of all public places in the state, we were disappointed. After all, the 1986 Surgeon General's Report on Smoking said there is no safe level of exposure to tobacco smoke. Kansans who have chosen not to smoke should have that choice wherever they go. The debate is over, passive smoke is harmful and non-smokers should not be forced to breathe it.

However, if we could choose only one public area to be included in a non-smoker protection act, we would choose restaurants. Complaints received by Kansans for NonSmokers Rights from members and non-members about tobacco smoke in restaurants is second only to the problem of tobacco smoke in the workplace. Workplaces were never covered in 2717.

Before the Topeka public smoking ordinance was passed (#15584) a Topeka television station editorialized that such a regulation was not needed in the city because "most" restaurants already provided for non-smokers. However, the reality was that only 11% of Topeka restaurateurs provided any space for non-smokers and some of that was marginal. Today, things have improved considerably for non-smoking diners in Topeka, but we are currently working with the city council to change the city regulations to be similiar with those proposed in House Bill 2717.

For some unknown reason the restaurant industry in Kansas has opposed any mandatory smoking regulations. KNSR would prefer that the industry handle the problem, but that has not worked. As in Topeka the restaurant industry has continued to ignor the wishes of the majority of Kansans who do not smoke and continue to cater to the less than 25% of adult Kansans who do smoke.

Why restaurant operators refuse to accomodate the needs and wishes of non-smokers when national polls (including Roper, Gallup, and USA Today) reveal a preference for non-smoking areas remains a mystery. Since the Topeka ordinance went into effect two years ago, I do not know of any restaurants that provide adequate non-smoking areas that have gone out of business as was direly predicted. I can identify two establishments that did not comply with the regulations that are now closed. I doubt that the lack of non-smoking areas forced them to close, but the failure to cater to non-smokers certainly did not save them.

Visit any restaurant that verbally offers diners a choice of smoking or non-smoking areas and you will find the majority of patrons in the non-smoking area. Prior to leaving the area last year to go to college, my daughter was a hostess at a local pizza restaurant. She offered each party a choice of smoking or non-smoking and reported that approximately 75% of the patrons chose non-smoking. She said that customers were often grouped in the non-smoking half of the establishment while the other side sat empty. She said there were occasionally more smokers than non-smokers, but that at no time was that extreme. The non-smoking section never remained empty while smokers jammed the other half.

For years the airline industry fought smoking restrictions. Some airlines still do, but last week Northwest Airlines announced that beginning April 23 all domestic flights would be non-smoking, admitting that 80% of their customers chose non-smoking seats and that smoke was harmful to non-smokers and flight crews. Why, April 23? That's the date that all domestic flights under two hours must be non-smoking due to government regulation. It should not have taken federal regulation to protect the majority of flyers who do not smoke, but it did. The passage of House Bill 2717 by the Senate of the State of Kansas can have the same effect. It will benefit the citizens of our state as well as the restaurant industry!

Hearing on HB 2717, March 29, 1988
Senate Public Heatlh & Welfare Committee

Rev. Richard Taylor
KANSANS FOR LIFE AT ITS BEST!

During the 1974 session of the Kansas Legislature, a syllable of some word would hang up in my throat at times, like when you have been eating peanuts and a portion gets lodged in a vocal chord and the word does not come out. It did not seem serious and I thought rest after the session would cause the problem to go away.

The problem did not go away so my wife and I made a trip to the Kansas University Medical Center where Dr. Kerschner found a leision on a vocal chord. He asked if I smoked. When told I had never purchased a pack of cigarettes, he immediately said such a leision is always benign in a non-smoker, but they must do a lab test and I should come back in 10 days.

Ten days later my wife and I walked in Dr. Kerschner's office. He was very solemn and looked me in the eye saying, "You have cancer on a vocal chord. Leave it there and it will kill you. If we remove the vocal chord, we'll hope for the best."

He indicated second hand smoke may have contributed to cancer on my vocal chord. The surgery was performed and I have lived with a voice handicap for 14 years.

Since 1974, research has confirmed that second hand smoke is a serious health problem. I have many smoking friends. They are fine people. They do not want to put at risk the health of others. Concerned smokers support legal restrictions for the sake of public health.

In schools, churches, Rotary clubs, etc. across Kansas I tell persons that if they want to keep their voice, they will probably choose not to smoke, because losing a vocal chord to cancer usually happens to a smoker. Then I play a short portion of my voice before cancer.

With sadness and a heavy heart, I read and hear of "smoker's rights". Is their right to smoke more important than my right to not be handicapped by losing a vocal chord to cancer? Please vote YES for HB 2717.

Respectfully yours,

Richard Taylor

BACKGROUND

As introduced by the House Public Health and Welfare Committee, this bill said "the total area of all designated smoking areas in any public place shall not exceed 50% of the total area of the public place."

That committee amended and then approved the bill to exempt any public place which has a total area of less than 1,000 square feet.

On the House floor a question was asked as to what would be done in bowling alleys and pool halls, paint a white line down the middle? The House Committee of the Whole refused to approve the bill.

Later on General Orders a compromise was presented that would make the 50% requirement apply only to restaurants. It was then approved by the House.

STATEMENT OF

THE AMERICAN LUNG ASSOCIATION

OF KANSAS

PRESENTED TO THE

PUBLIC HEALTH AND WELFARE COMMITTEE

OF THE KANSAS SENATE

CONCERNING HOUSE BILL 2717

Senate Public Health & Welfare
March 29, 1988
Attachment 15

Prepared by Roberta B. Kunkle, Smoking Education Consultant,
American Lung Association of Kansas, March 29, 1988.

In the 1987 legislative session, House Bill 2412 was passed. It mandated that public places post areas as either smoking or nonsmoking. Our organization supported this legislation, but requested that smoking areas should comprise no more than 50 percent of public places. This language was not incorporated and resulted in the Attorney General ruling that proprietors are free to designate their entire buildings as smoking zones. House Bill 2717 was introduced to clarify the original intent. As often happens in the legislature process, certain items have been deleted. The Bill now requires that 50 percent of all restaurant seating (those under 1,000 square feet are excluded) be posted as nonsmoking. Although the American Lung Association of Kansas (ALA/K) wishes that the Bill still included all public places, we feel that this is a positive step towards protecting the health of all Kansans and making it more comfortable for all nonsmokers to patronize restaurants. Individuals with heart disease, emphysema, and other respiratory problems will be able to dine out without having to inhale secondhand smoke. Many of these individuals now avoid restaurants and other public places.

The most current survey, conducted by the Centers for Disease Control, lists the percentage of smokers at only 26 percent; thus, allowing 50 percent of the seating for smoking permitted tables which is more than equitable to those who still smoke. According to the 1985 Gallup "Survey of Attitudes Towards Smoking," 75 percent of respondents answered "yes" to the question, Should Smokers Refrain From Smoking in the Presence of Nonsmokers? If tobacco were a new product, its manufacture, sale and consumption would never be approved by the U.S. Food and Drug Administration.

Each year 350,000 premature deaths occur among smokers. This is the equivalent of two jumbo jets crashing each day with no survivors. The Surgeon General of the United States has asked the American Lung Association and all voluntary health agencies to work towards a Smoke-Free Society in the year 2000. We hope that this Committee will send this Bill to the full Senate for consideration. Passage of this Bill will be a positive step in promoting good health for all Kansans.

# # #

Tobacco's toll on America

AMERICAN LUNG ASSOCIATION®
The Christmas Seal People®

15-2

An American Tragedy

A cigarette scarring America is more than a symbolic image: It is a reality. This report presents many of the tragic consequences of cigarette smoking on this nation's physical, economic and social health.

Nicotine is the addicting agent in cigarettes, and one of the most addictive drugs in use today. Cigarette smoking prematurely kills more people than heroin, cocaine and other illicit drugs, plus automobile accidents, homicide, suicide and alcohol abuse combined. In our deep concern over drug abuse, we must never forget that tobacco by far takes the greatest toll on our population.

Yet the tobacco industry legally markets and promotes this cause of 90 percent of lung cancer deaths and 80-to-90 percent of deaths due to chronic obstructive pulmonary diseases, especially chronic bronchitis and emphysema. The American Lung Association calls for an end to tobacco advertising and promotion.

To replace the many thousands of smokers who die and who quit each year, the tobacco companies target new consumers among youth, women, blue-collar workers and minorities. Although cigarette companies wave a self-proclaimed "voluntary code of ethics" that restricts them from appealing to youth, we find tobacco product names linked to sports events, rock concerts, teen fashion items and other youth-oriented promotions.

ALA actively supports an increase in the federal cigarette excise tax to 32 cents a pack. Such a tax would not only help cover the economic burden tobacco places on this country—$23 billion in direct and $30 billion in indirect costs—but it has been proven to be a deterrent to smoking, especially among young people and low-income groups.

And as more and more research reveals that nonsmokers pay a physical price because of involuntary smoking, ALA's strong support of nonsmokers' rights becomes all the more meaningful and necessary.

For the health of this nation, the ALA must reach the public with our messages and educational programs. Yet the American Lung Association is a David to the tobacco industry's Goliath. Although he prevailed, even David needed stones in his slingshot. If we are to continue our combat with this giant, we need funds for our ammunition: lung research, smoking prevention programs, educational campaigns on the dangers of smoking, and our legislative programs.

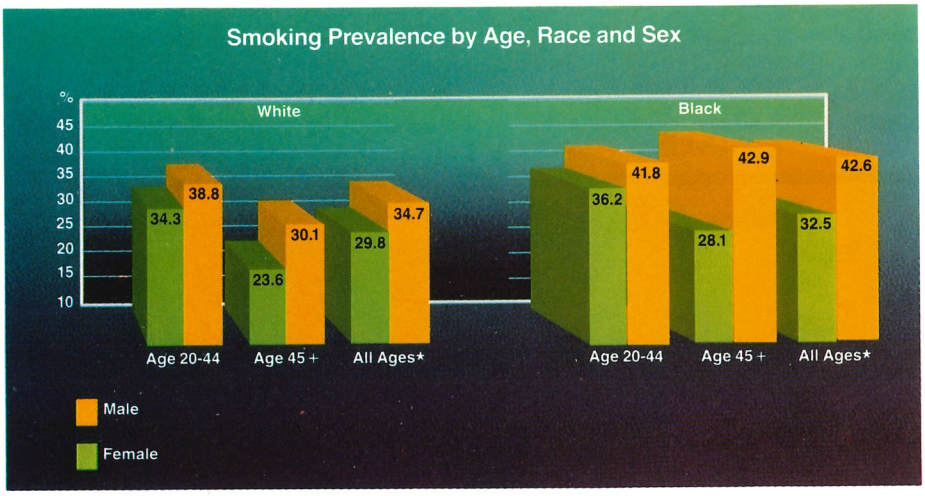
Tobacco's Toll on America

Tobacco. During the 17th century it was considered a magical herb. Smoked in a silver pipe, it was believed to cure toothache, banish melancholy, relieve stuffy heads.

They didn't know then that pipe smoking causes cancer of the tongue and lip.

Smoking was also prescribed as a cure for female "hysteria." They didn't know then that pregnant women who smoke increase their risk of bearing stillborn babies.

Nobody knew then that cigarettes would one day be responsible for more than 350,000 premature deaths a year in the United States. Nobody knew then that smoking kills people.



*Age Adjusted

Source: National Center for Health Statistics, National Health Interview Survey, 1983

Graph: American Lung Association—The Christmas Seal People®

In 1603, a plague year, English schoolboys at Eton were required to smoke. Not occasionally, but every morning. It was thought that smoking would protect them from the plague. Boys who didn't smoke were whipped.

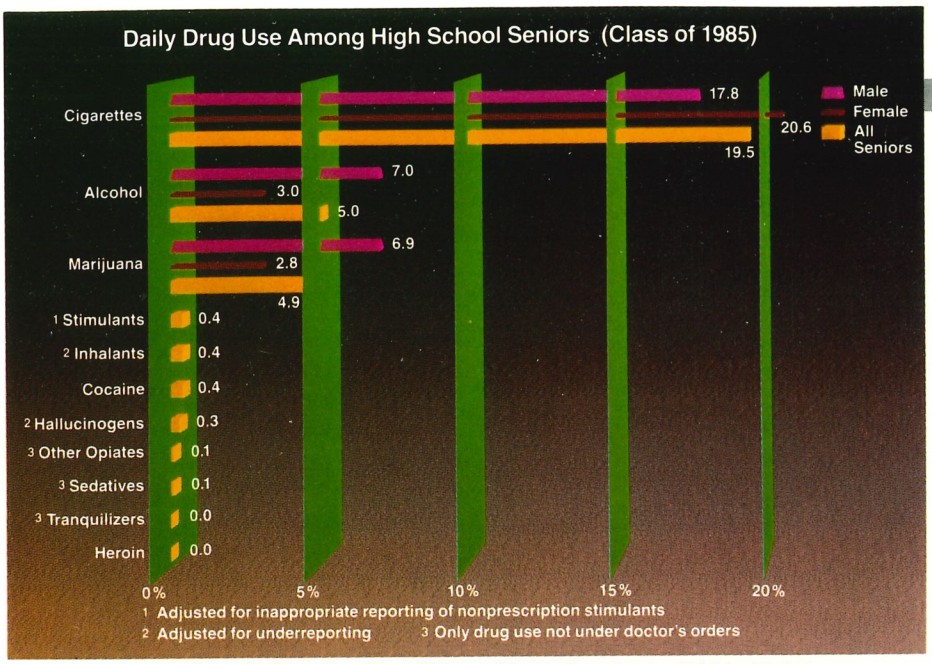
They didn't know then that smoking causes chronic bronchitis, emphysema, and lung cancer.

Now we know. We also know that:

- Nicotine, in the words of the American Medical Association, is "our most deadly addictive drug." It is highly toxic: A single drop of pure nicotine on the tongue can kill a person. The addictive nature of nicotine has been established beyond question.
- Smoking kills more people every year than all other drugs and alcohol combined.
- Smoking kills eight times as many Americans each year as die in motor vehicle accidents.
- Smoking kills more Americans each year than died in battle in World War II and Vietnam put together.
- Fires started by cigarettes take some 1,600 lives and cause about 4,000 injuries each year in the United States.
- Smoking destroys lung tissue. It constricts blood vessels and replaces oxygen in blood cells with carbon monoxide—a poisonous gas.

Even though well over 40,000 scientific studies have demonstrated the physical harm done by smoking tobacco, surveys tell us that many Americans still don't know about the dangers of cigarette smoking:

- Almost half of all smokers do not know that most cases of lung cancer are caused by smoking, or that the vast majority of victims struck by lung cancer die from the disease.
- Millions of smokers—between 13 and 17 percent of the 54,000,000 Americans now smoking—still don't realize that smoking is hazardous to their health.
- More than half of all Americans do not realize that cigarette smoking is addictive.

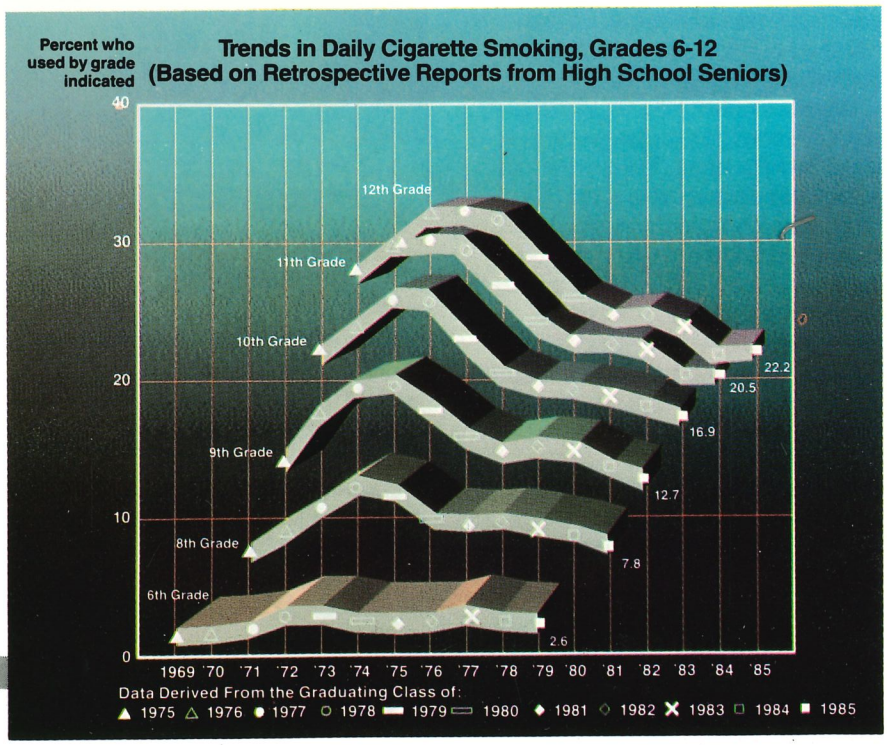


Source: National Institute on Drug Abuse, 1985 Survey of Drug Use Among American High School Students, College Students, and Other Young Adults

Graph: American Lung Association—The Christmas Seal People®

The mission of the American Lung Association is the prevention and control of all lung disease. Because an overwhelming percentage of lung disease and death simply wouldn't occur were it not for cigarette smoking, a major ongoing ALA goal is to educate the public—especially the young—to the grim toll tobacco takes on smokers and nonsmokers. And ALA provides the smoking cessation materials and programs that can free those who are chained to this devastating addiction.

- Almost one out of three people are unaware that even "light" smoking (fewer than 10 cigarettes per day) is dangerous.
- Now the public must be informed about a relatively new body of knowledge that is documenting the dangers of involuntary or passive smoking. Recent research studies and voluminous reports issued by prestigious scientific institutions and the U.S. Surgeon General are now documenting and investigating the detrimental physical effects of involuntary smoking on the nonsmoker.



Source: National Institute on Drug Abuse, 1985 Survey of Drug Use Among American High School Students, College Students, and Other Young Adults

Graph: American Lung Association—The Christmas Seal People®

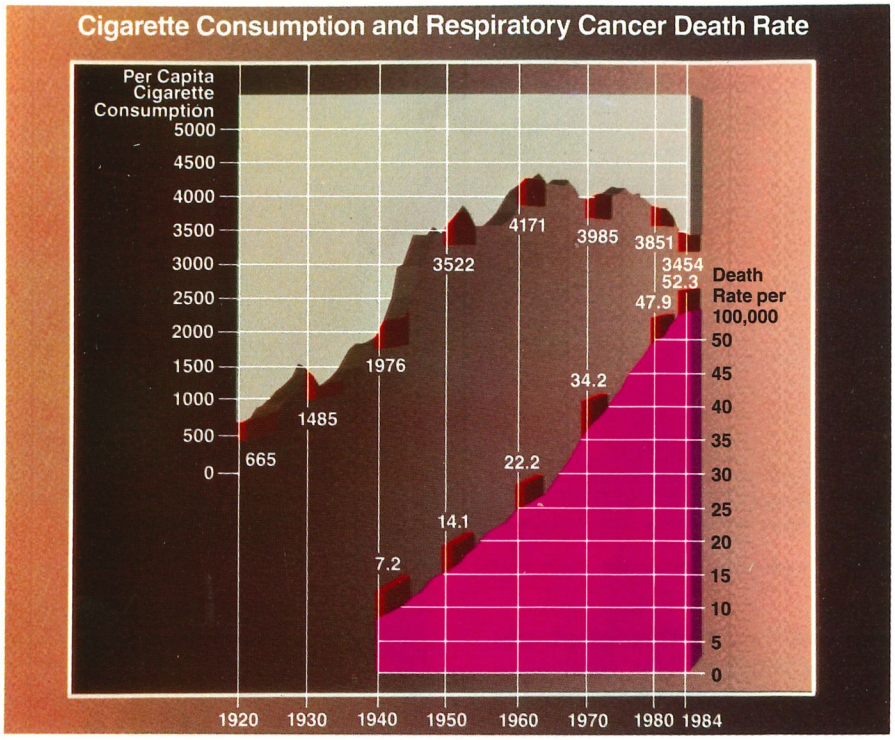
The Lethal Effects

When the American cigarette industry was born on April 30, 1884—the day the cigarette-making machine was perfected—nobody knew that cigarette smoking caused lung cancer. How could they? Lung cancer was virtually nonexistent in the United States at that time.

The picture is sharply different today. In 1986, approximately 130,000 people died of lung cancer—the leading cause of cancer death in both men and women.

The increase in cigarette smoking and the parallel rise in lung cancer is not coincidental. Apologists for the tobacco industry still profess skepticism, but the truth is plain: There is no question that cigarette smoking is the major cause of lung cancer. The evidence is overwhelming. Of every 100 cases of the disease, about 85 are caused by smoking.

When a smoker inhales, a mixture of gaseous and particulate poisons is taken into the lungs. The smoke can paralyze or destroy cilia—the tiny hairlike projections lining the bronchial tubes that normally help keep foreign particles out of the airways and lungs. Smoke can also destroy or damage alveoli—the tiny air sacs in the lungs in which carbon dioxide, the body's gaseous metabolic waste, is exchanged for life-giving oxygen. These are only two of the many destructive processes initiated by the inhalation of tobacco smoke, which includes such noxious components as nicotine, tar, carbon monoxide, arsenic, insecticide residues, cyanide and sulphur.



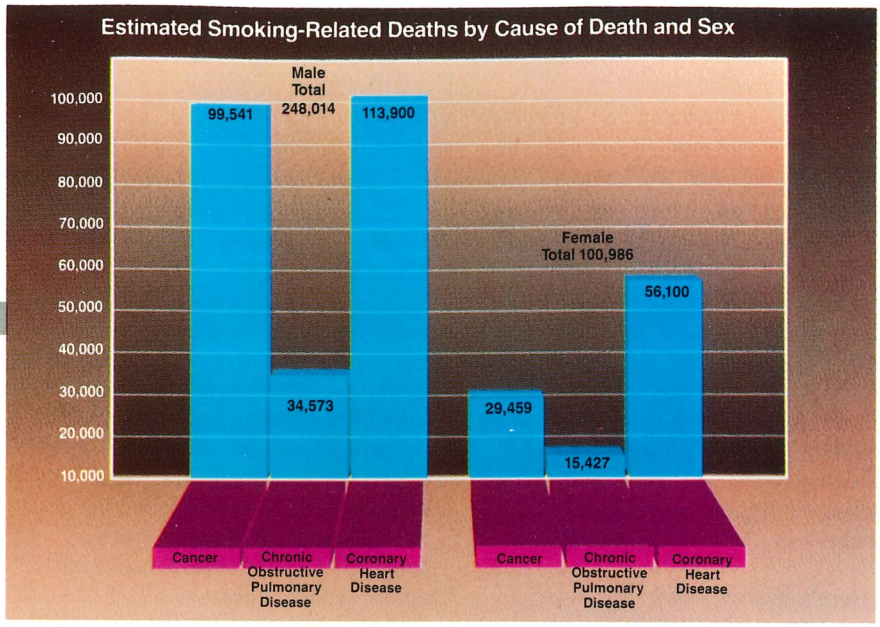
Sources: National Center for Health Statistics, Final Mortality Statistics, 1940-1984; U.S. Department of Agriculture, Economic Research Service, 1985 (per capita cigarette consumption data includes individuals 18 years and older, and overseas forces, 1940 to date)

Note: Correlation calculations show a statistically significant relationship between respiratory cancer and per capita cigarette consumption and support the view that there is a 20-year lag relationship between smoking and respiratory cancer mortality.

Graph: American Lung Association—The Christmas Seal People®

It should be no surprise, then, that in addition to lung cancer, smoking is also the major cause of chronic obstructive pulmonary disease (COPD)—primarily chronic bronchitis and emphysema—and is responsible for 80-to-90 percent of the almost 70,000 deaths a year due to COPD. As early as 1964, cigarette smoking was recognized as the major cause of chronic bronchitis. The risk of heavy smokers incurring chronic bronchitis and emphysema is as much as 30 times greater than for nonsmokers.

Smoking not only ravages the lungs, it plays havoc on the heart—30-to-40 percent of cardiovascular disease deaths are attributed to cigarette smoking. It also can aggravate circulatory diseases of the arms and



Sources: Attributable risk estimates for cancer by Doll and Peto, 1981; for other diseases, by Rice, Hodgson, et al., *The Milbank Quarterly*, Vol. 64, No.4, 1986

Graph: American Lung Association—The Christmas Seal People®

legs to the point where amputation is required.

Will it be a boy or a girl? A pregnant woman's most heartfelt response is likely to be, "I don't care, as long as it's healthy." But babies born to women who smoke are less likely to be healthy. A pregnant woman who smokes has an increased risk of miscarriage or stillbirth and a greater chance of having a low-birthweight infant.

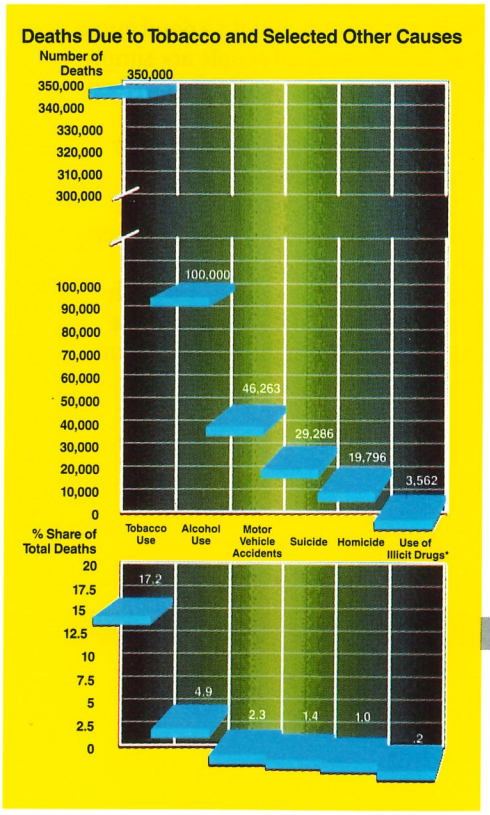
So it's not only smokers themselves who suffer: Infants feel the effects as well. Children do, too. Investigators have found repeatedly that the children of parents who smoke are sick more often; they have more colds and much higher rates of bronchitis and pneumonia. And cigarette smoke can have an adverse effect on children with asthma and can precipitate bronchial spasms.

Involuntary smoking—breathing the smoke produced by others' cigarettes—affects spouses as well. Several studies have suggested that nonsmoking wives who live with heavy smokers were twice as likely to die of lung cancer as were the wives of men who didn't smoke. And a recent U.S. study showed that such nonsmoking wives were also three times more likely to suffer heart attacks.

The only way to avoid smoking-related diseases is to eliminate tobacco smoke. To help people quit smoking, the American Lung Association—with its medical section, the American Thoracic Society—has developed several multifaceted smoking cessation programs and approaches. These include "Freedom From Smoking® in 20 Days," a self-help, step-by-step manual for kicking the habit; "A Lifetime of Freedom From Smoking®," a maintenance manual for ex-smokers; a seven-session Freedom From Smoking® clinic for groups; and "In Control®: A Video Freedom From Smoking® Program," which can be used by individuals or in groups.

There is also ALA's Smoking and Pregnancy program for expectant mothers and their health care providers. This educational program reaches out to pregnant women who smoke during a time when they are most apt to listen to the no-smoking health message. A new self-help manual, "Freedom From Smoking® for You and Your Baby," complements the program by providing a 10-day plan for smoking cessation and by carrying a strong message to stay off cigarettes after the baby is born.

But there are still the millions upon millions who right now are suffering from smoking-related lung diseases or who will be struck by them in the near or far future. There are no cures for chronic bronchitis, emphysema or lung cancer. Only research can someday attain these medical miracles. The ALA energetically supports and campaigns for lung research while functioning as the world's foremost disseminator of lung research to the scientific community.



*Estimate based on 75 medical examiners reporting from 26 metropolitan areas in 1985

Sources: National Center for Health Statistics, Advance Report of Final Yearly Mortality Statistics, 1984; U.S. Department of Health and Human Services, Office on Smoking and Health; National Institute on Alcohol Abuse and Alcoholism; National Institute on Drug Abuse

Graph: American Lung Association—The Christmas Seal People®

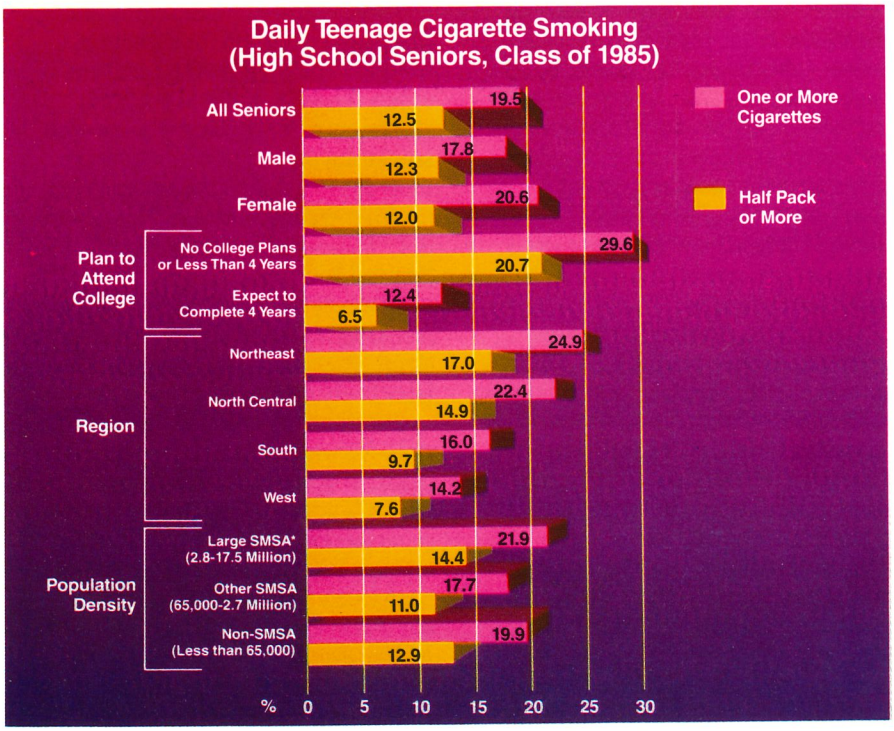
Who Smokes?

Eighty million packs of cigarettes will be sold today. Who's buying them? The demographics of smoking are revealing. Some of the numbers are heartening; many are cause for concern.

Here's what we know:

The 54,000,000 American adults who smoke constitute nearly a third (31 percent) of the population. Thirty-three percent of adult men are smokers—but that figure is down from 52 percent in 1964. Among adult women, 28 percent now smoke. That figure, too, is down—from 34.2 percent in 1964—but the decline is clearly less dramatic for women. Nearly 20 percent of American high school seniors smoke, while 15 percent of youths age 12 to 17 have picked up the habit.

The good news: More than 41 million Americans are former smokers, and one out of three smokers attempts to give up the habit every year. The bad news: Many people—mostly teenagers—start smoking every year. Two thirds of adult smokers took up the habit during their adolescence.



*Standard Metropolitan Statistical Area, reflecting a metropolitan area and its adjacent communities

Source: National Institute on Drug Abuse, 1985 Survey of Drug Use Among American High School Students, College Students, and Other Young Adults

Graph: American Lung Association—The Christmas Seal People®

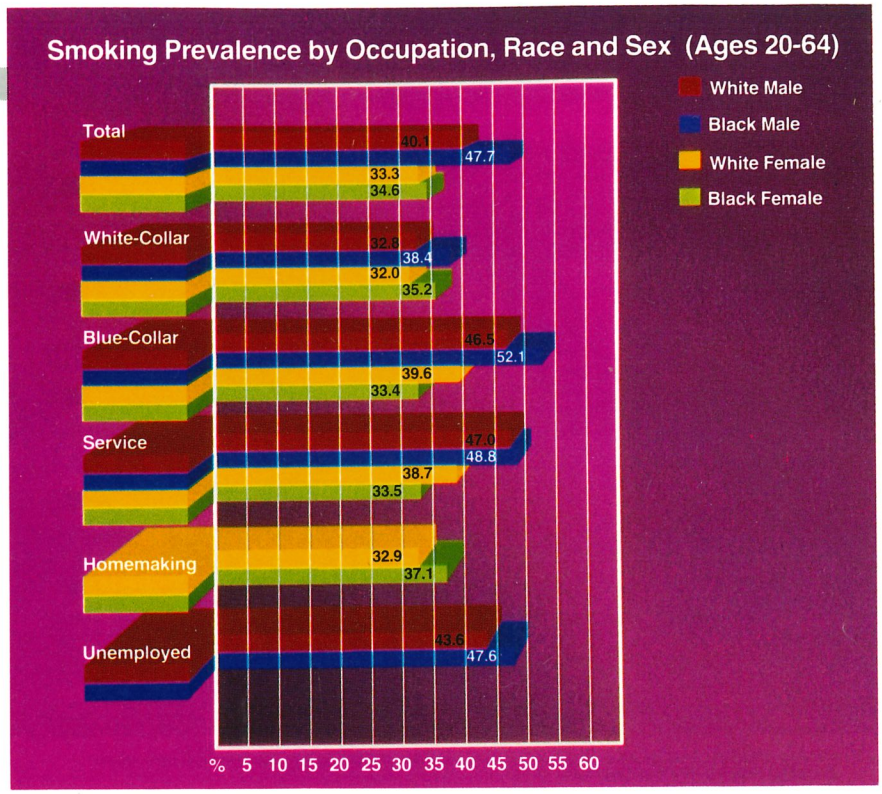
- ***If You're Smart, You Won't Smoke.***

The better educated people are, the less likely they are to smoke. Those with a graduate degree, for instance, smoke less than those with a baccalaureate, who in turn smoke less than those who graduated from high school. And high school graduates are less likely to be smokers than high school dropouts. In general, adolescent smokers have poorer grades than their nonsmoking peers. They're also more likely to hold part-time jobs while in school, to come from single-parent and lower-income families; and they're less likely to go on to college.

Surveys don't explain the reasons for those findings, but it's a good guess that better educated people are simply better informed about the health hazards of smoking.

- ***If You're a Female Teenager Who Smokes, Your Number's Up.***

Smoking has generally declined since the mid-1960s—except for teenage girls. Since 1976, teenage girls surveyed in their senior year of high school have smoked at a higher rate (currently 20.6 percent) than senior boys (17.8 percent).



Source: National Center for Health Statistics, National Health Interview Surveys, 1978-1980 (combined); Report of the U.S. Surgeon General on the Health Consequences of Smoking, 1985

Graph: American Lung Association—The Christmas Seal People®

- *What Color Is Your Collar?*

If you're a white-collar worker, you are less likely to smoke (36 percent) than those in blue-collar occupations (47 percent). Working women are somewhat more likely than housewives to be smokers.

- *Old Enough to Know Better.*

You're less likely to smoke if you're over 65. Among men, smoking rates are highest for those age 35 to 54; among women, the highest rates occur in the 20-to-24 and 35-to-44 age groups.

- *Does Race Matter?*

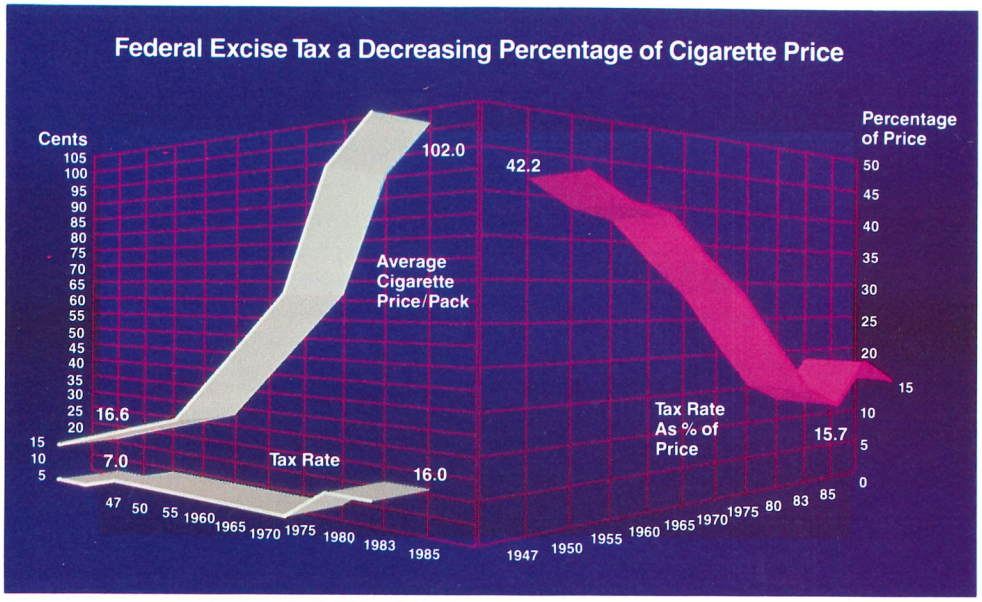
Blacks have a higher rate of smoking than whites—and they also have the highest rates of lung cancer and heart disease of any population group. About 39.1 percent of black men smoke, compared to 32 percent of all men in the country.

Black women, too, have higher rates of smoking than their white female counterparts: Among young black women age 20 to 44, the percentage who smoke is 36.2 as compared to the 34.3 percent of white women in the same age range who are smokers. At age 45 and over, the percentage is 28.1 for black women versus 23.6 percent for white women.

Of course, there are tobacco print and billboard advertising campaigns specifically targeted to appeal to blacks.

We know that smokers start young, and that the family environment and parental modeling play a key role in the decision to smoke or not. That's why so many ALA programs and efforts are aimed at educating the family and, especially, young people. Our goal and top priority is a smoke-free society; it begins with a smoke-free family.

What It Costs Us



Sources: **Harvard University, Institute for the Study of Smoking Behavior and Policy; U.S. Department of Agriculture; *Economic Report of the President*, 1985**

Graph: American Lung Association—The Christmas Seal People®

Any smoker knows that the habit isn't cheap. At $1.20 a pack, the annual price tag can run $400 to $1,000 a year or more—not counting lighters, let alone the shirts and ties, skirts and dresses, and furniture and carpets ruined by cigarette burns.

Most smokers shrug off these costs as relative peanuts. Indeed they are, compared to the other costs of smoking—in health care and lost productivity. According to one estimate, those costs amount to $54 billion: $30.4 billion per year in lost work and productivity and $23.3 billion in medical costs. In 1984, the American Thoracic Society (ATS) stated that a middle-aged man who smokes heavily will lose $34,000 during his lifetime because of extra medical bills and lost income. And don't forget the cost of fires: In 1984, Americans lost property valued at $410 million in fires caused by smoking.

It's not only the smoker who loses. Nonsmokers, in fact, shoulder much of the health cost burden by paying higher health insurance premiums and higher taxes, which fund such programs as Medicare and Medicaid and disability benefits.

Smokers should pay more of those costs. One way to get them to do that is to increase the excise tax on cigarettes—currently 16 cents a pack. If this tax truly reflected the economic costs of smoking to the American public, it would run at least $2.00 a pack.

But there's a far more important benefit of the tax than the dollar aspect: Studies indicate that higher excise taxes can help save lives by discouraging hundreds of thousands of young people from starting to smoke—and inducing some established smokers to quit.

The ALA/ATS Government Relations Office in Washington, D.C., unflaggingly works to bring the case for higher cigarette excise taxes—as well as other lung health-related measures—before the federal legislative and executive branches.

The cigarette excise tax is also a major priority of the Coalition on Smoking OR Health, which unites the American Lung Association, American Cancer Society and American Heart Association into an influential Washington force to battle the tobacco industry power.

Excise taxes are only one way to help achieve a "smoke-free society"—the

Surgeon General's goal for the year 2000. Other efforts have been aimed at prohibiting or restricting smoking in public buildings and in places where people work, including military establishments. A 1985 Gallup survey commissioned by ALA found that 87 percent of those polled favored a ban on smoking at work, or separate smoking and no-smoking areas. (Ninety-two percent of nonsmokers and even 80 percent of smokers agreed.) At this writing, 40 states and the District of Columbia now have laws limiting smoking in public places, and a growing number of states, counties and towns have laws governing smoking in workplaces.

American industry is responding with no-smoking policies as well. Hundreds of companies and agencies have adopted policies that regulate or restrict smoking on the job. Many are entirely smoke-free; some companies simply refuse to hire smokers.

Those company policies restricting smoking may reflect a concern for the bottom line: Bosses know that employees who smoke cost them money in lost productivity, more absences from work and higher insurance premiums. In other cases, such policies reflect management's fear of losing key people to premature death or disability. In more and more companies, too, nonsmokers are objecting to being forced to breathe secondhand smoke, and smoke-free environments are increasingly becoming a workplace morale-builder.

So that employees can do their jobs without suffering from involuntary smoking—and to help those workers who want to be free of their smoking addiction—the ALA has developed a multifaceted Freedom From Smoking® At Work program for use in business and industry. And as a result of the ALA's and local Lung Associations' vigorous efforts in city, state and national legislative arenas, *The New York Times* called the American Lung Association the "champion of nonsmokers' rights."

Economic Costs of Smoking for All Diseases Attributed to Smoking* (1984 Estimates, in Millions)

Age and Sex	Total Costs	Direct Health Care Expenditures	Indirect Costs: Morbidity	Indirect Costs: Mortality
Male				
Under 65	$29,060	$7,899	$6,220	$14,941
65 and Over	7,434	5,477	281	1,676
Female				
Under 65	11,180	4,973	2,715	3,492
65 and Over	6,037	4,989	70	978
Total	$53,711	$23,338	$9,286	$21,087

*Includes cancer and diseases of the respiratory and circulatory systems

Source: Rice, Hodgson, et al., *The Milbank Quarterly*, Vol. 64, No. 4, 1986

Graph: American Lung Association—The Christmas Seal People℠

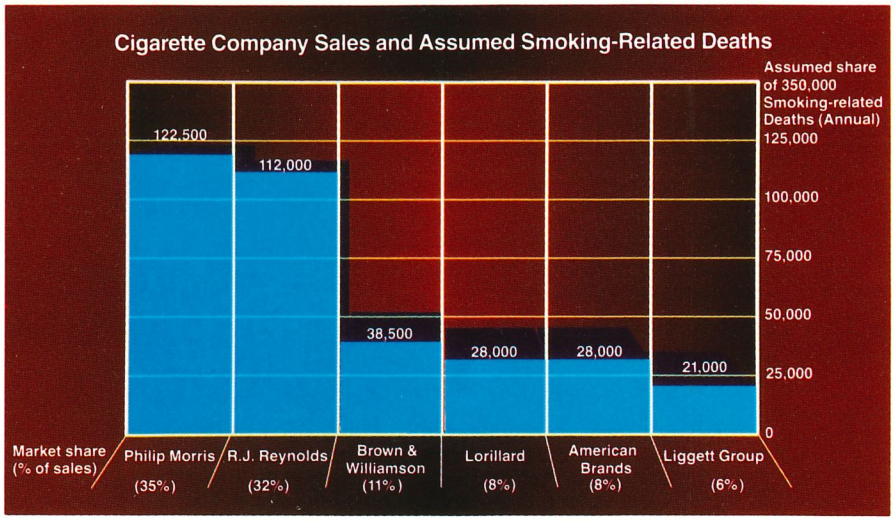
The Tobacco Smoke Screen

The words in this Surgeon General's warning—one of four required to be printed on cigarette packs and in ads—leave no room for doubt: "Smoking causes lung cancer, heart disease, emphysema, and may complicate pregnancy."

The phrasing is unequivocal, but you won't hear tobacco industry spokesmen admit that smoking can kill you. "We question the statistical correlation between cigarettes and diseases," says one lobbyist. That posture is typical of the industry, which continues to pretend that, shucks, tobacco isn't all that bad for you.

They now know better than that. They know that approximately 41 million Americans have quit smoking; that antismoking forces are more vocal and effective than ever; that per capita cigarette consumption is flat or declining.

These are key reasons for tobacco companies to diversify—notably by buying such giant consumer goods companies as General Foods, Nabisco and Del Monte. Such acquisitions only add more weight to the tobacco-controlled advertising clout already wielded over America's media. Even before these massive business acquisitions, too many newspapers and magazines kept antismoking health stories to a bare minimum, rather than jeopardize millions of dollars worth of cigarette ads.



Sources: The Maxwell Report; National Center for Health Statistics, *Health, United States*, 1984

Note: This chart illustrates the division of responsibility that would be assigned if a court decision were to hold cigarette manufacturers liable for deaths caused by their products and based liability on market share. Deaths per manufacturer based on the assumption that number of deaths is solely a reflection of market share. These assumptions do not take into account potential differences among cigarette brands.

Graph: American Lung Association—The Christmas Seal People®

The tobacco industry knows how to blow smoke. Its stratagems:

- ***Cry "Free Speech!"***

The tobacco lobby raises the flag of the First Amendment to justify its advertising and promotion under the guise of "free speech." A recent U.S. Supreme Court decision, however, indicates that it is constitutional to ban or restrict advertising of even a legal product if it is considered detrimental.

- ***Appeal to Women and Teenagers.***

In the six years after Virginia Slims were first marketed to young women, the percentage of 12-to-18-year-old girls who smoked nearly doubled—from 8.4 percent to 15.3 percent. "You've come a long way, baby"—in the wrong direction.

- ***Look Respectable.***

That's not easy when you're selling a lethal product. One way the tobacco industry does it is by producing expensive promotions and cultural events in concert with museums and other

highly respectable organizations—linkages that do an extremely cost-effective job of polishing a cigarette company's image.

- ***Spend a Billion or Two.***

Cigarettes are the most heavily marketed consumer product in America: The tobacco industry spent over $2 billion on cigarette advertising and promotion in 1984. Savvy tobacco marketers know how to spend it, too—not only on print advertising and billboards, but on events with high visibility, big crowds and throngs of young people: rock concerts, automobile and horse racing, athletic events. They not only sponsor such events, but find them ideal for a promotional technique called sampling—the giving away of free packets of cigarettes and tobacco.

Is sampling effective? It must be. One study showed that from 1970 to 1983, there was a tenfold increase in the amount cigarette companies spent on sampling promotions. They've also stepped up other kinds of promotion, including point-of-purchase displays and coupon rebates.

- ***Run, Don't Walk, to Capitol Hill.***

Through political action committees (PACs), the tobacco industry also contributes campaign funds to dozens of congressmen (more than 200, in fact, during the election campaigns of 1981 and 1982). During 1984 and 1985, the Philip Morris PAC alone contributed nearly $500,000 to congressmen of both parties. Would those contributions help keep alive the federally funded tobacco price support program? The answer is obvious.

The tobacco industry can well afford to mount such extravagantly expensive advertising, promotional, political, and business-acquisition campaigns. An estimated $30.7 billion in cigarette sales flow into the tobacco industry coffers each year. Balanced against the tobacco industry's massive financial assets are the millions of lives and billions of dollars in medical care and productivity lost since the first cigarette was rolled. This debit side will continue to erode the physical and economic health of our nation as long as tobacco takes its tragic toll on America.

Cigarette Advertising and Promotional Expenditures 1970-1983 (in Millions)

	TV/ Radio	Magazines & Newspapers	Outdoor & Transit	Other	Total Advertising	Promotional	Total	Advertising as % of Total
1970	$217.4	$ 64.2	$ 11.7	$ 21.4	$ 314.7	$ 46.3	$ 361.0	87.2%
1971	2.2	157.6	60.6	31.2	251.6	*	*	*
1972	0	159.2	67.5	30.9	257.6	*	*	*
1973	0	157.7	63.2	26.6	247.5	*	*	74.5
1974	0	195.1	71.4	40.3	306.8	*	*	67.3
1975	0	235.7	95.2	35.3	366.2	125.1	491.3	69.0
1976	0	263.8	122.0	44.2	430.0	209.1	639.1	68.6
1977	0	364.0	141.8	46.2	552.0	247.5	799.5	69.1
1978	0	371.2	171.9	57.4	600.5	274.5	875.0	66.8
1979	0	498.7	184.2	66.1	749.0	334.4	1083.4	64.5
1980	0	530.6	219.5	79.8	829.9	412.4	1242.3	58.0
1981	0	649.3	250.0	99.0	998.3	549.4	1547.7	56.9
1982	0	632.1	291.0	117.0	1040.1	753.7	1793.8	
1983	0	589.0	321.9	170.1	1081.0	819.8	1900.8	

*Not Available

Source: Federal Trade Commission, *Report to Congress*, June 1985, as revised December 1985

Graph: American Lung Association—The Christmas Seal People®

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(612) 227-8014

ALA of Hennepin County
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Minneapolis, MN 55404
(612) 871-7332

ALA of Ramsey County
614 Portland Ave.
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Helena, MT 59601
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Reno, NV 89510-7056
(702) 323-LUNG

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ALA of New Jersey
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Union, NJ 07083
(201) 687-9340

ALA of Central New Jersey
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(201) 388-4556

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Albuquerque, NM 87108
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Brooklyn, NY 11201
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New York Lung Assn./
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Flushing, NY 11375
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Rochester, NY 14620
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ALA-Hudson Valley
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ALA of Mid-New York
23 South St.
Utica, NY 13501
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ALA of Northwestern Ohio
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ALA of Southwestern Ohio
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(215) 372-4322

ALA of Bucks County
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(215) 343-6420

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(215) 876-8297

ALA of Lancaster County
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The American Lung Association—the Christmas Seal People®—is the oldest nationwide voluntary health agency in the United States. Originally founded in 1904 to combat tuberculosis, today the Association, its 138 affiliated Associations throughout the country and its medical section, the American Thoracic Society, are dedicated to the control and prevention of all lung diseases and some of their related causes, including smoking, air pollution and occupational lung hazards. ALA's public health education and research programs are supported by donations to Christmas Seals® and by other voluntary contributions.

AMERICAN LUNG ASSOCIATION
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