

MINUTES OF THE HOUSE HEALTH AND HUMAN SERVICES COMMITTEE

The meeting was called to order by Chairman Brenda Landwehr at 1:30 p.m. on March 10, 2009, in Room 784 of the Docking State Office Building.

All committee members were present.

Committee staff present:

Norm Furse, Office of the Revisor of Statutes  
Melissa Calderwood, Kansas Legislative Research Department  
Reed Holwegner, Kansas Legislative Research Department  
Janet Grace, Committee Assistant

Conferees appearing before the Committee:

Secretary Roderick Bremby, Kansas Department of Health and Environment ([Attachment 1, 2](#))  
Dr. Rick Kellerman, University of Kansas - Medical Center - Wichita ([Attachment 3](#))  
Sonja Armbruster, Kansas Public Health ([Attachment 4](#))  
Brad Smith, Via Christi Health System ([Attachment 5](#))  
Jace Smith ([Attachment 6](#))  
Dr. Karen Kelly, University of Kansas Cancer Center ([Attachment 7](#))  
Dr. John Neuberger, University of Kansas - Medical Center in Kansas City ([Attachment 8, 9, 10, 11](#))  
Dr. Trent Davis, Salina, Kansas ([Attachment 12](#))  
Dave Pomeroy ([Attachment 13](#))  
Louie Riederer, Johnny's Tavern ([Attachment 14](#))  
Graham Bailey, Blue Cross Blue Shield ([Attachment 15](#))  
Bob Strawn, General Atomics ([Attachment 16](#))  
Teresa Walters, Emporians for Drug Awareness ([Attachment 17](#))  
Cathy Porter, American Heart Association Volunteer ([Attachment 18](#))  
Gail Dicus, American Heart Association Volunteer ([Attachment 19](#))  
Dr. Thomas Schultz, Intern Medicine Residency, KU Medical Center- Wichita ([Attachment 20](#))  
Teresa Carter, Mid-Kansas Affiliate of Susan G. Komen for the Cure ([Attachment 21](#))  
Molly Johnson, Senior University of Kansas ([Attachment 22](#))  
Sarah Tidwell, Kansas State Nurses Association ([Attachment 23](#))  
Phil Black, Dean of Academic Affairs, Brown Mackie College - Salina ([Attachment 24](#))  
Salvador Romero, Kansans for Nonsmokers Rights, Topeka ([Attachment 25](#))  
Dr. James Hamilton, American Cancer Society ([Attachment 26](#))  
Chad Austin, Kansas Hospital Association ([Attachment 27](#))  
James Hanus, Oncology Nurse ([Attachment 28](#))  
Debra Zehr, President, Kansas Association of Homes and Services for the Aging ([Attachment 29](#))  
Debbie Fox, Kansas Respiratory Care Society ([Attachment 30](#))  
Rev. Craig Loya, Kansas Faith Alliance for Health Reform ([Attachment 31](#))  
John Neuenswander, Director of Advocacy, American Lung Association ([Attachment 32](#))  
Bobbi Sauder, MSN, Clean Air Emporia ([Attachment 33](#))  
Marcy Morris ([Attachment 34](#))  
Donna Bartholomew, Owner, Skaets Steak Shop, Hutchinson ([Attachment 35](#))  
Aubrey Patterson, Respiratory Care Shift Supervisor, Wesley Medical Center, Wichita ([Attachment 36](#))  
Jayne Hellebust, Executive Director, Tobacco-Free Kansas Coalition ([Attachment 37](#))  
Ron Gaches, Gaches, Braden and Association ([Attachment 38](#))  
Sarah Bradshaw, Portia Turner, Michelle Wishon, Elisabeth Gaither ([Attachment 39](#))  
James Gardner, Primary Care Physicians of Manhattan ([Attachment 40](#))  
Jeff Levin, University Bookstore, Inc. ([Attachment 41](#))  
James Sherow, Manhattan City Commissioner ([Attachment 42](#))  
Bruce Snead, Manhattan City Commissioner ([Attachment 43](#))  
Dan Morin, Kansas Medical Society ([Attachment 44](#))  
Tracy Russell, Joyce Morrison, Clean Air Kansas ([Attachment 45](#))  
Yvonne Gibbons, Del Myers, Saline County Health Department ([Attachment 46](#))  
Stuart Little, Johnson County ([Attachment 46](#))

## CONTINUATION SHEET

Minutes of the House Health and Human Services Committee at 1:30 p.m. on March 10, 2009, in Room 784 of the Docking State Office Building.

Others attending:

See attached list

Chairman Landwehr called the meeting to order.

**SB 25 - State-wide prohibition on smoking in indoor public areas.** Revisor Norm Furse provided the committee with a brief overview of **SB 25**.

The hearing today is for proponent testimony.

Secretary Roderick Bremby, Kansas Department of Health and Environment (KDHE), introduced the new State Health Director, Dr. Jason Phillips. Secretary Bremby provided the highlights from his attachments for the committee. (Attachments 1, 2) The Surgeon General is very clear and there is no more debate about the health consequences from second-hand smoke. Clean Indoor Air laws saves lives. KDHE supports this bill. **SB 25** would be instrumental in health reform and save money, as almost \$1 billion a year is spent in Kansas on tobacco related issues. Currently, 400 Kansans die each year due to second-hand smoke. Additionally, 2100 heart attacks a year are attributed to second-hand smoke. The committee proceeded with questions for Secretary Bremby. Tobacco products are the only products in the U.S. market that, when used as indicated, are life-threatening. If the products were banned totally, they would probably be available on the black market. This ban could shape the environment to have people smoke less frequently. Virginia, the home of Marlboro, passed a Clean Air Act. KDHE would not support an amendment for a statewide ban and then let the counties decide if they want to override the vote. Public health is a concern for all and is a statewide issue. KDHE's goal is to keep children from smoking. KDHE understands that parents will smoke at home. If it was an individual rights question, KDHE would not be here; it is a public health issue. A total ban on smoking would be the first of its kind in the US. It is the most effective approach (outright ban) that would affect millions of people and dollars. KDHE is monitoring effects and approaches of different Clean Air Acts around the U.S. and tobacco is the issue. It kills more Americans than anything else—440,000 each year. There are immediate reductions in emergency rooms with heart attacks when a Clean Air Act is in place.

Dr. Rick Kellerman, representing the University of Kansas Medical Center-Wichita, Medical Society of Sedgwick County, and the Kansas Academy of Family Physicians, provided testimony in favor of this bill. (Attachment 3) The medical societies emphasize the relationship between cigarette smoking and diseases (particularly the heart). A Clean Air Act (24 states have such Acts) provides an immediate reduction of heart attacks in emergency rooms. The KU hospital campus used to allowing smoking but it no longer is allowed on the campus. Public health is a good public statewide policy issue. It is confusing to have different entities in different counties concerning smoking. If smoking was banned statewide and counties were given the opportunity to vote against it, Dr. Kellerman believes most counties would vote to support a smoking ban. Four hundred people die in Kansas yearly from second-hand smoke. What is not known, but acknowledged, is the direct effect from second-hand smoke on children, the chronic ear infections, sore throats, upper respiratory infections, etc. The statistics are overwhelming with the occurrence of the type of lung cancer (squamous cell lung cancer) that second-hand smoke causes.

Sonja Armbruster, Kansas Public Health Association (KPHA), provided testimony in favor of this bill. (Attachment 4) Ms. Armbruster firmly believes the Surgeon General's report is clear and accurate. Tobacco control, including a statewide Clean Indoor Air law, is their number one priority. Ms. Armbruster's attachment provides details on KPHA's agreement on the needs for Kansas and the facts concerning second-hand smoke and the support of a comprehensive law banning it. KPHA does not support letting communities override a statewide ban. KPHA wants everyone protected and a fair and even playing field for all.

Brad Smith, Research Nurse in Cancer Control from Wichita Community Clinical Oncology Program at Via Christi Health System, supports this bill. (Attachment 5) Via Christi's mission is to provide the best healthcare to patients without regard to the ability to pay. In addition to providing care to the sick and



injured, they also believe it is equally important to promote good health. One of the ways in which Via Christi achieves this goal is by education of their patients and the public on the health risks associated with smoking. They witness first-hand the variety of ways that smoking impacts peoples lives. Lung cancer is one of the most obvious diseases related to smoking, and in its more aggressive form, is not noticed until it has already metastasized. Not all patients with lung cancer are smokers. They also care for patients who have emphysema. Via Christi supports **SB 25** as it represents an important step in protecting the health of Kansas while generating savings in smoking-related illnesses and diseases.

Jace Smith spoke in support of **SB 25**. (Attachment 6) Mr. Smith used to work in a bar and now has asthma due to second-hand smoke. Mr. Smiths asthma was diagnosed at age 21. He takes medications and uses his inhaler for his asthma and will need to do so for the rest of his life. He needs to avoid triggers for his asthma such as second-hand smoke. Mr. Smith spoke for those who need to work and are working in unhealthy environments. Employees should not have to risk their health for a paycheck. Mr. Smith encourages the committee to join the other states and make Kansas a smoke free environment. As the U.S. Surgeon General concluded when issuing a groundbreaking report in June 2006, "The debate is over. The science is clear: Second-hand smoke is not a mere annoyance, but a serious health hazard that causes premature death and disease in children and nonsmoking adults." Any exemptions in the bill, should not put an employee's at health risk in order to get a paycheck. Mr. Smith urges the committee to let the FDA take the lead on a total ban of smoking.

Dr. Karen Kelly, University of Kansas Cancer Center, provided testimony in favor of this bill. (Attachment 7) There are no measures to detect lung disease until the lung cancer is in the end stage. Tobacco smoke causes lung cancer in 87% of the patients presenting with this disease. One thousand five hundred thirty people died from lung cancer in Kansas last year. The use of tobacco is addictive to smokers and it exposes both smokers; and bystanders who share the environment with smokers, to the same deadly toxins. Extensive studies document the contributions of tobacco products to the causation of several types of cancers, most notably lung cancer. It kills more people than breast, colon and prostate cancers combined. Tobacco use is a major factor in chronic and acute cardiovascular disease. By enforcing smoke-free laws thousands of lives would be saved and prevent this type of pain and suffering. States that experienced the most significant decline in cancer-related deaths are states that adopted a Clean Indoor Air Act and implemented a Tobacco User fee. Sixty-four cancer centers specializing in research excellence state that second-hand smoke is a major cause of cancer. Dr. Kelly supports the bill with the exemptions because of compromise. She would prefer to have a total ban on smoking but would be willing to compromise and amend the exceptions. Nursing homes present a challenge due to a room being a home, the number of elderly that are addicted to smoking, and what area should be restricted. As a policy perspective, passing this bill will save a tremendous amount of lives with or without the exceptions.

Dr. John Neuberger, University of Kansas School of Medicine, Kansas City, Department of Preventive Medicine an Public Health, provided proponent testimony for **SB 25**. (Attachments 8 ,9, 10, 11) Dr. Neuberger presented the Surgeon General's report that provides data on second-hand smoke causing heart and respiratory issues. Numerous health problems, including heart and lung disease, result from exposure to second-hand smoke and this exposure needs to be controlled in public places and workplaces. Dr. Neuberger conducted a survey about indoor smoking and had a response rate was of 90% for cities and 50% for individuals. The survey represented more than 650,000 people. Sixty percent of respondents felt states should mandate a comprehensive indoor smoking regulation with local enforcement. Heart attacks have decreased within one-year in the states that implemented this type of ban. Our rights do not include the right to harm and potentially kill workers/patrons of the bars/restaurants. Dr. Neuberger supports a stronger ban and making it more consistent with the restrictions to minimize disparities.

Dr. Trent Davis, Neurologist, strongly supports **SB 25**. (Attachment 12) Salina is the first city in the state to enact a Clean Air ordinance. Tobacco smoke is one of the few devices that has an immediate effect on everyone. Smoking and non-smoking sections do not work. Employees in bars and restaurants often don't have health insurance, therefore someone else is paying a large health care tab. From a financial aspect, Kansas needs to be proactive and reduce steps to have people need health care. Forty percent of children that have parents that smoke will start smoking. Employees that work in a smoke-free environment have a 38% chance of discontinuing their smoking. Kansas needs to be a smoke free state. There are larger cost savings from reduced bronchitis, pneumonia, sinusitis, sore throat, SIDS, numerous cancer types, including lung cancer, ulcers, and employee absenteeism from a Clean Air Act. Dr. Davis

stated one can not opt out of other major health issues such as vaccines. One should not be able to opt out of smoking. Why is a state ban needed; why not 'choose' where we eat, etc? This is really an OSHA issue. The employees are under-represented in the political system and they fear losing jobs if they speak out against smoking. Everyone is paying to take care of health issues from second-hand smoke and we will run out of money. Dr. Davis would prefer to have the exceptions removed, which would make it a stronger bill. It is the exposure nonsmokers to second-hand smoke that is the issue. Nursing homes are the elderly persons' homes. Hospitals have to set the example for others by having a smoking ban on the campus. The culture needs to be changed and it has to start somewhere. The fewer places someone can smoke will help some stop smoking, which is a positive step. Restricting smoking for public health safety is similar to having speed limits and seat belts which are in the interest of public health.

Ms. Crissa Potter provided testimony in support of this bill. Ms. Potter discussed asthma and provided a demonstration on how asthmatics breath, like through a straw all the time. Second-hand smoke provides a severe trigger. Ms. Potter read an article from Blue Cross Blue Shield stating any amount of exposure of second-hand smoke can be harmful. Eight hours a day of second-hand smoke in a restaurant is equivalent to six cigarettes. Smoking kills people; there should be a law against it.

Dave Pomeroy provided proponent testimony for **SB 25**. ([Attachment 13](#)) Mr. Pomeroy discussed the inability to always have a choice as to where he can eat. Mr. Pomeroy rides his bicycle across the state and goes into whatever restaurant that is available. He is diabetic and needs to adhere to an eating schedule. The ability to chose between a smoking and non-smoking restaurant is not always an option in Kansas.

Louie Riederer, Johnny's Tavern, is in support of **SB 25**. ([Attachment 14](#)) Mr. Riederer has come full circle on smoking bans. He was initially against them but now fully supports them. Ninety nine percent of his customers have commented on how much they liked being in a non-smoking environment. The patrons are happier and the employees are healthier despite the fears that smoking restrictions would hurt his business. A patchwork of local ordinances now in place makes things more confusing for customers and puts owners at a disadvantage. Everybody needs to play by the same rules, whether you are a bar, restaurant or private club.

Graham Bailey from Blue Cross Blue Shield (BCBS), supports this bill. ([Attachment 15](#)) In a 12-month period they insured and paid for 32, 000 heart attacks at a cost of \$34,500 each with a total cost of \$70 million in health care costs. In the Pueblo, CO, study there was an immediate reduction in heart attacks (41%) during their 3-year study. This is about \$30 million dollars in savings in health care. They looked at two other communities that did not pass a Clean Air Act. There was no change in their heart attack rates. They did not look at asthma, cancers, etc. Ten to twelve percent of healthcare costs is attributed to smoking. BCBS is a leader by not allowing smoking on their campus.

Bob Strawn, General Atomics, provided testimony in support of this bill. ([Attachment 16](#)) They asked that the State level the playing field and let the free market allocate resources regulated by a wide government. Currently there is a patchwork throughout Kansas, which this is putting cities at a disadvantage. Pass this bill to let the free market work.

Remaining proponent conferees will be added to Thursday's hearing.

Offering written testimony in support of **SB 25** were:  
Teresa Walters, Emporians for Drug Awareness ([Attachment 17](#))

Cathy Porter, American Heart Association Volunteer ([Attachment 18](#))

Gail Dicus, American Heart Association Volunteer ([Attachment 19](#))

Dr. Thomas Schultz, Intern Medicine Residency KU Med - Wichita ([Attachment 20](#))

Teresa Carter, Mid-Kansas Affiliate of Susan G. Komen for the Cure ([Attachment 21](#))

Molly Johnson, Senior KU ([Attachment 22](#))

Sarah Tidwell, KSNA ([Attachment 23](#))

Phil Black, Dean of Academic Affairs, Brown Mackie College - Salina([Attachment 24](#))

Salvador Romero ([Attachment 25](#))

Dr. James Hamilton, American Cancer Society ([Attachment 26](#))

Chad Austin, Kansas Hospital Association ([Attachment 27](#))

James Hanus, Oncology Nurse ([Attachment 28](#))

Debra Zehr, President, Kansas Association of Homes and Services for the Aging ([Attachment 29](#))

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John Neuenswander, Director of Advocacy, American Lung Association ([Attachment 32](#))

Bobbi Sauder, MSN, Clean Air Emporia ([Attachment 33](#))

Marcy Morris ([Attachment 34](#))

Donna Bartholomew, Owner, Skaets Steak Shop, Hutchinson ([Attachment 35](#))

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Tracy Russell and Joyce Morrison, Clear Air Kansas, ([Attachment 45](#))

Yvonne Gibbons and Del Myers, Saline County Health Department ([Attachment 46](#))

Stuart Little, Johnson County ([Attachment 47](#))

The next meeting is scheduled for March 11, 2009.

The meeting was adjourned at 3:26 p.m.



# HOUSE HEALTH & HUMAN SERVICES COMMITTEE

DATE: 3-10-09

NAME	REPRESENTING
Rachel Schmidt	KHI
Sharon Thomas	KHI
Candace Ayars	KDAE
<del>John Neubauer</del>	Self
Ethan Patterson	Little Govt.
Bob HARVEY	AARP KANSAS
Rick Kellerman	KUSM-W
Caressa Pethu	David Young
Sarah Tidwell	KSNA
Leggy Johnson	Nichita Medical Research
Tracy Russell	KS Health Consumer Coalition
Corrie Edwards	KS Health Consumer Coalition
Ernest Kutzy	AARP
Lindsay Kimball	CAKC
Graham Bailey	BlueCross Blue Shield of Kansas
JOHN NEUENSWANDER	AMERICAN LUNG ASSOCIATION
Jonis Ambruster	Kansas Public Health Association
Bobbi D. Saudey	Clean Air Emporia
Trent W. Davis, MD	Saline County Tobacco Prevention Coalition, Saline, KS

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## Economic Impact of Clean Indoor Air Laws

The 2006 Surgeon General's Report "The Health consequences of Involuntary Exposure to Tobacco Smoke" states that evidence from peer-reviewed studies shows that smoke-free policies and regulations do not have an adverse economic impact on the hospitality industry.

Below are the highlighted results from some of the studies noted in the 2006 Surgeon General's Report.

- A study (Glantz and Smith, 1994) of sales tax data in California and Colorado found no effect on restaurant retail sales in communities with clean indoor air ordinances compared to sales in communities without ordinances. The communities studied varied in population from a few thousand to more than 300,000 and the length of time the ordinances were in effect ranged from a few months to more than 10 years. A follow-up study (Glantz and Smith, 1997) found the same result.
- Studies on retail restaurant sales in a small suburb of Austin, Texas, (CDC, 1995) and in El Paso, Texas, (CDC 2004) also found ordinances banning smoking had no effect on sales.
- A New York City study actually found an increase in sales after a smoking ban. Using taxable sales data from eating and drinking establishments in New York City, Hyland and colleagues (1999) observed a 2.1% increase in sales following implementation of a citywide smoking ban in restaurants compared with sales two years before the law took effect.
- A study in California (Cowling and Bond 2005) on tax revenue data from 1990 to 2002 also found an increase in restaurant revenues after a statewide smoke-free restaurant law and an increase in bar revenues after a statewide smoke-free bar law. A study of the California smoke-free bar law found the proportion of bar patrons who reported they were just as likely or more likely to visit bars that had become smoke-free increased from 86% three months after the law took effect in 1998 to 91% in 2000 (Tang et al. 2003).
- A recent report from New York City (New York City Department of Finance, 2004) assessed all four economic indicators (sales tax receipts, revenues, employment, and the number of licenses issued) and reported increases in all four economic measures after the passage of city and state clean indoor air laws. Restaurant and bar business tax receipts had increased by 8.7%; employment in restaurants and bars had increased by about 2,800 seasonally adjusted jobs, and there was a net gain of 234 active liquor licenses for restaurants and bars.
- Glantz and Charlesworth (1999) examined hotel revenues and tourism rates in six cities before and after passage of smoke-free restaurant ordinances. The results indicated that smoke-free restaurant ordinances do not adversely affect tourism revenues and may, in fact, increase tourism (Glantz 2000).

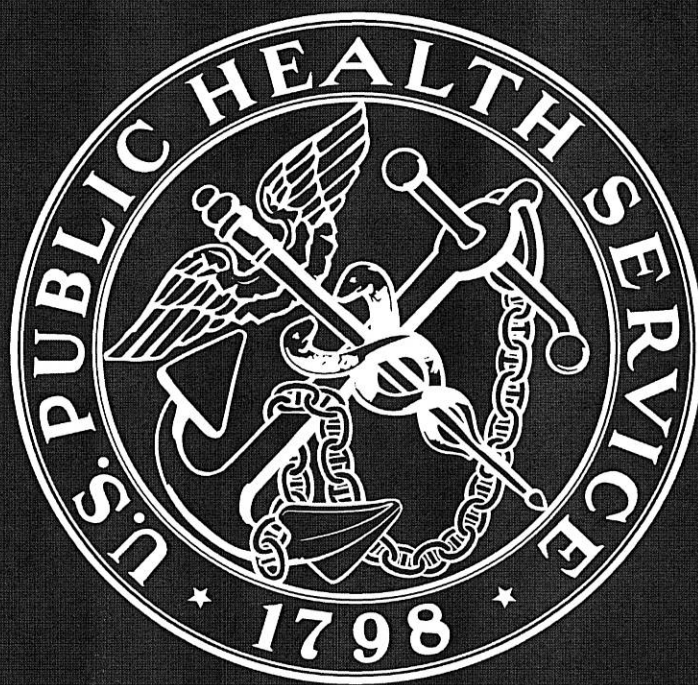
While some organizations may site results of adverse economic impact, the Surgeon General's Report states, "Discrepancies between economic impact studies of clean indoor air laws conducted either by the tobacco industry or by non-industry-supported scientists can be traced in part to variations in the types of data analyzed. Studies commissioned by or for the tobacco industry to assess the economic impact of smoke-free restaurant and bar regulations have generally relied on proprietor predictions or estimates of changes in sales, rather than on actual sales or revenue data. Such estimates are subject to significant reporting bias and are viewed with skepticism because they do not constitute empirical data."



Member 22

# The Health Consequences of Involuntary Exposure to Tobacco Smoke

A Report of the Surgeon General



Department of Health and Human Services

HEALTH AND HUMAN SERVICES  
DATE: 03/10/09  
ATTACHMENT: 2



Centers for Disease Control and Prevention  
Coordinating Center for Health Promotion  
National Center for Chronic Disease Prevention and Health Promotion  
Office on Smoking and Health

**Suggested Citation**

U.S. Department of Health and Human Services. *The Health Consequences of Involuntary Exposure to Tobacco Smoke: A Report of the Surgeon General – Executive Summary*.  
U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, Coordinating Center for Health Promotion, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health, 2006

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# The Health Consequences of Involuntary Exposure to Tobacco Smoke

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A Report of the Surgeon General

2006

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES  
Public Health Service  
Office of the Surgeon General  
Rockville, MD



## Message from Michael O. Leavitt

*Secretary of Health and Human Services*

This Surgeon General's report returns to the topic of the health effects of involuntary exposure to tobacco smoke. The last comprehensive review of this evidence by the Department of Health and Human Services (DHHS) was in the 1986 Surgeon General's report, *The Health Consequences of Involuntary Smoking*, published 20 years ago this year. This new report updates the evidence of the harmful effects of involuntary exposure to tobacco smoke. This large body of research findings is captured in an accompanying dynamic database that profiles key epidemiologic findings, and allows the evidence on health effects of exposure to tobacco smoke to be synthesized and updated (following the format of the 2004 report, *The Health Consequences of Smoking*). The database enables users to explore the data and studies supporting the conclusions in the report. The database is available on the Web site of the Centers for Disease Control and Prevention (CDC) at <http://www.cdc.gov/tobacco>. I am grateful to the leadership of the Surgeon General, CDC's Office on Smoking and Health, and all of the contributors for preparing this important report and bringing this topic to the forefront once again.

Secondhand smoke, also known as environmental tobacco smoke, is a mixture of the smoke given off by the burning end of tobacco products (sidestream smoke) and the mainstream smoke exhaled by smokers. People are exposed to secondhand smoke at home, in the workplace, and in other public places such as bars, restaurants, and recreation venues. It is harmful and hazardous to the health of the general public and particularly dangerous to children. It increases the risk of serious respiratory problems in children, such as a greater number and severity of asthma attacks and lower respiratory tract infections, and increases the risk for middle ear infections. It is also a known human carcinogen (cancer-causing agent). Inhaling secondhand smoke causes lung cancer and coronary heart disease in nonsmoking adults.

We have made great progress since the late 1980s in reducing the involuntary exposure of nonsmokers in this country to secondhand smoke. The proportion of nonsmokers aged 4 and older with a blood cotinine level (a metabolite of nicotine) indicating exposure has declined from 88 percent in 1988–1991 down to 43 percent in 2001–2002, a decline that exceeds the *Healthy People 2010* objective for this measure. Despite the great progress that has been made, involuntary exposure to secondhand smoke remains a serious public health hazard that can be prevented by making homes, workplaces, and public places completely smoke-free. As of the year 2000, more than 126 million residents of the United States aged 3 or older still are estimated to be exposed to secondhand smoke. Smoke-free environments are the most effective method for reducing exposures. *Healthy People 2010* objectives address this issue and seek optimal protection of nonsmokers through policies, regulations, and laws requiring smoke-free environments in all schools, workplaces, and public places.

## Foreword

This twenty-ninth report of the Surgeon General documents the serious and deadly health effects of involuntary exposure to tobacco smoke. Secondhand smoke is a major cause of disease, including lung cancer and coronary heart disease, in healthy nonsmokers.

In 2005, it was estimated that exposure to secondhand smoke kills more than 3,000 adult nonsmokers from lung cancer, approximately 46,000 from coronary heart disease, and an estimated 430 newborns from sudden infant death syndrome. In addition, secondhand smoke causes other respiratory problems in nonsmokers such as coughing, phlegm, and reduced lung function. According to the CDC's National Health Interview Survey in 2000, more than 80 percent of the respondents aged 18 years or older believe that secondhand smoke is harmful and nonsmokers should be protected in their workplaces.

Components of chemical compounds in secondhand smoke, including nicotine, carbon monoxide, and tobacco-specific carcinogens, can be detected in body fluids of exposed nonsmokers. These exposures can be controlled. In 2005, CDC released the *Third National Report on Human Exposure to Environmental Chemicals*, which found that the median cotinine level (a metabolite of nicotine) in nonsmokers had decreased across the life stages: by 68 percent in children, 69 percent in adolescents, and 75 percent in adults, when samples collected between 1999 and 2002 were compared with samples collected a decade earlier. These dramatic declines are further evidence that smoking restrictions in public places and workplaces are helping to ensure a healthier life for all people in the United States.

However, too many people continue to be exposed, especially children. The recent data indicate that median cotinine levels in children are more than twice those of adults, and non-Hispanic blacks have levels that are more than twice as high as those of Mexican Americans and non-Hispanic whites. These disparities need to be better understood and addressed.

Research reviewed in this report indicates that smoke-free policies are the most economic and effective approach for providing protection from exposure to secondhand smoke. But do they provide the greatest health impact. Separating smokers and nonsmokers in the same airspace is not effective, nor is air cleaning or a greater exchange of indoor with outdoor air. Additionally, having separately ventilated areas for smoking may not offer a satisfactory solution to reducing workplace exposures. Policies prohibiting smoking in the workplace have multiple benefits. Besides reducing exposure of nonsmokers to secondhand smoke, these policies reduce tobacco use by smokers and change public attitudes about tobacco use from acceptable to unacceptable.

Research indicates that the progressive restriction of smoking in the United States to protect nonsmokers has had the additional health impact of reducing active smoking. In November 2005, CDC's Tobacco-Free Campus policy took full effect in all facilities owned by CDC in the Atlanta area. As the Director of the nation's leading health promotion and disease prevention agency, I am proud to support this effort. With this commitment, CDC continues to protect the health and safety of all of its employees and serves as a role model for workplaces everywhere.

Julie Louise Gerberding, M.D., M.P.H.  
Director  
Centers for Disease Control and Prevention  
and  
Administrator  
Agency for Toxic Substances and Disease Registry

## Preface

*from the Surgeon General,  
U.S. Department of Health and Human Services*

Twenty years ago when Dr. C. Everett Koop released the Surgeon General's report, *The Health Consequences of Involuntary Smoking*, it was the first Surgeon General's report to conclude that involuntary exposure of nonsmokers to tobacco smoke causes disease. The topic of involuntary exposure of nonsmokers to secondhand smoke was first considered in Surgeon General Jesse Steinfeld's 1972 report, and by 1986, the causal linkage between inhaling secondhand smoke and the risk for lung cancer was clear. By then, there was also abundant evidence of adverse effects of smoking by parents on their children.

Today, massive and conclusive scientific evidence documents adverse effects of involuntary smoking on children and adults, including cancer and cardiovascular diseases in adults, and adverse respiratory effects in both children and adults. This 2006 report of the Surgeon General updates the 1986 report, *The Health Consequences of Involuntary Smoking*, and provides a detailed review of the epidemiologic evidence on the health effects of involuntary exposure to tobacco smoke. This new report also uses the revised standard language of causality that was applied in the 2004 Surgeon General's report, *The Health Consequences of Smoking*.

Secondhand smoke is similar to the mainstream smoke inhaled by the smoker in that it is a complex mixture containing many chemicals (including formaldehyde, cyanide, carbon monoxide, ammonia, and nicotine), many of which are known carcinogens. Exposure to secondhand smoke causes excess deaths in the U.S. population from lung cancer and cardiac related illnesses. Fortunately, exposures of adults are declining as smoking becomes increasingly restricted in workplaces and public places. Unfortunately, children continue to be exposed in their homes by the smoking of their parents and other adults. This exposure leads to unnecessary cases of bronchitis, pneumonia and worsened asthma. Among children younger than 18 years of age, an estimated 22 percent are exposed to secondhand smoke in their homes, with estimates ranging from 11.7 percent in Utah to 34.2 percent in Kentucky.

As this report documents, exposure to secondhand smoke remains an alarming public health hazard. Approximately 60 percent of nonsmokers in the United States have biologic evidence of exposure to secondhand smoke. Yet compared with data reviewed in the 1986 report, I am encouraged by the progress that has been made in reducing involuntary exposure in many workplaces, restaurants, and other public places. These changes are most likely the major contributing factors to the more than 75 percent reduction in serum cotinine levels that researchers have observed from 1988 to 1991. However, more than 126 million nonsmokers are still exposed. We now have substantial evidence on the efficacy of different approaches to control exposure to secondhand smoke. Restrictions on smoking can control exposures effectively, but technical approaches involving air cleaning or a greater exchange of indoor with outdoor air cannot. Consequently, nonsmokers need protection through the restriction of smoking in public places and workplaces and by a voluntary adherence to policies at home, particularly to eliminate exposures of children. Since the release of the 1986 Surgeon General's report, the public's attitude and social norms toward secondhand smoke exposure have changed significantly—a direct result of the growing body of scientific evidence on the health effects of exposure to secondhand smoke that is summarized in this report.



Finally, clinicians should routinely ask about secondhand smoke exposure, particularly in susceptible groups or when a child has had an illness caused by secondhand smoke, such as pneumonia. Because of the high levels of exposure among young children, their exposure should be considered a significant pediatric issue. Additionally, exposure to secondhand smoke poses significant risks for people with lung and heart disease. The large body of evidence documenting that secondhand smoke exposures produce substantial and immediate effects on the cardiovascular system indicates that even brief exposures could pose significant acute risks to older adults or to others at high risk for cardiovascular disease. Those caring for relatives with heart disease should be advised not to smoke in the presence of the sick relative.

An environment free of involuntary exposure to secondhand smoke should remain an important national priority in order to reach the *Healthy People 2010* objectives.

Richard Carmona, M.D., M.P.H., F.A.C.S.  
Surgeon General

## Executive Summary

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The topic of passive or involuntary smoking was first addressed in the 1972 U.S. Surgeon General's report (*The Health Consequences of Smoking*, U.S. Department of Health, Education, and Welfare [USDHEW] 1972), only eight years after the first Surgeon General's report on the health consequences of active smoking (USDHEW 1964). Surgeon General Dr. Jesse Steinfeld had raised concerns about this topic, leading to its inclusion in that report. According to the 1972 report, nonsmokers inhale the mixture of sidestream smoke given off by a smoldering cigarette and mainstream smoke exhaled by a smoker, a mixture now referred to as "secondhand smoke" or "environmental tobacco smoke." Cited experimental studies showed that smoking in enclosed spaces could lead to high levels of cigarette smoke components in the air. For carbon monoxide (CO) specifically, levels in enclosed spaces could exceed levels then permitted in outdoor air. The studies supported a conclusion that "an atmosphere contaminated with tobacco smoke can contribute to the discomfort of many individuals" (USDHEW 1972, p. 7). The possibility that CO emitted from cigarettes could harm persons with chronic heart or lung disease was also mentioned.

Secondhand tobacco smoke was then addressed in greater depth in Chapter 4 (Involuntary Smoking) of the 1975 Surgeon General's report, *The Health Consequences of Smoking* (USDHEW 1975). The chapter noted that involuntary smoking takes place when nonsmokers inhale both sidestream and exhaled mainstream smoke and that this "smoking" is "involuntary" when "the exposure occurs as an unavoidable consequence of breathing in a smoke-filled environment" (p. 87). The report covered exposures and potential health consequences of involuntary smoking, and the researchers concluded that smoking on buses and airplanes was annoying to nonsmokers and that involuntary smoking had potentially adverse consequences for persons with heart and lung diseases. Two studies on nicotine concentrations in nonsmokers raised concerns about nicotine as a contributing factor to atherosclerotic cardiovascular disease in nonsmokers.

The 1979 Surgeon General's report, *Smoking and Health: A Report of the Surgeon General* (USDHEW 1979), also contained a chapter entitled "Involuntary Smoking." The chapter stressed that "attention to involuntary smoking is of recent vintage, and only limited information regarding the health effects of

such exposure upon the nonsmoker is available" (p. 11–35). The chapter concluded with recommendations for research including epidemiologic and clinical studies. The 1982 Surgeon General's report specifically addressed smoking and cancer (U.S. Department of Health and Human Services [USDHHS] 1982). By 1982, there were three published epidemiologic studies on involuntary smoking and lung cancer, and the 1982 Surgeon General's report included a brief chapter on this topic. That chapter commented on the methodologic difficulties inherent in such studies, including exposure assessment, the lengthy interval during which exposures are likely to be relevant, and accounting for exposures to other carcinogens. Nonetheless, the report concluded that "Although the currently available evidence is not sufficient to conclude that passive or involuntary smoking causes lung cancer in nonsmokers, the evidence does raise concern about a possible serious public health problem" (p. 251).

Involuntary smoking was also reviewed in the 1984 report, which focused on chronic obstructive pulmonary disease and smoking (USDHHS 1984). Chapter 7 (Passive Smoking) of that report included a comprehensive review of the mounting information on smoking by parents and the effects on respiratory health of their children, data on irritation of the eye, and the more limited evidence on pulmonary effects of involuntary smoking on adults. The chapter began with a compilation of measurements of tobacco smoke components in various indoor environments. The extent of the data had increased substantially since 1972. By 1984, the data included measurements of more specific indicators such as acrolein and nicotine, and less specific indicators such as particulate matter (PM), nitrogen oxides, and CO. The report reviewed new evidence on exposures of nonsmokers using biomarkers, with substantial information on levels of cotinine, a major nicotine metabolite. The report anticipated future conclusions with regard to respiratory effects of parental smoking on child respiratory health (Table 1.1).

Involuntary smoking was the topic for the entire 1986 Surgeon General's report, *The Health Consequences of Involuntary Smoking* (USDHHS 1986). In its 359 pages, the report covered the full breadth of the topic, addressing toxicology and dosimetry of tobacco smoke; the relevant evidence on active smoking;

**Table 1.1** Conclusions from previous Surgeon General's reports on the health effects of secondhand smoke exposure

Disease and statement	Surgeon General's report
<b>Coronary heart disease:</b> "The presence of such levels" as found in cigarettes "indicates that the effect of exposure to carbon monoxide may on occasion, depending upon the length of exposure, be sufficient to be harmful to the health of an exposed person. This would be particularly significant for people who are already suffering from. . .coronary heart disease." (p. 7)	1972
<b>Chronic respiratory symptoms (adults):</b> "The presence of such levels" as found in cigarettes "indicates that the effect of exposure to carbon monoxide may on occasion, depending upon the length of exposure, be sufficient to be harmful to the health of an exposed person. This would be particularly significant for people who are already suffering from chronic bronchopulmonary disease. . . ." (p. 7)	1972
<b>Pulmonary function:</b> "Other components of tobacco smoke, such as particulate matter and the oxides of nitrogen, have been shown in various concentrations to affect adversely animal pulmonary. . .function. The extent of the contributions of these substances to illness in humans exposed to the concentrations present in an atmosphere contaminated with tobacco smoke is not presently known." (pp. 7-8)	1972
<b>Asthma:</b> "The limited existing data yield conflicting results concerning the relationship between passive smoke exposure and pulmonary function changes in patients with asthma." (p. 13)	1984
<b>Bronchitis and pneumonia:</b> "The children of smoking parents have an increased prevalence of reported respiratory symptoms, and have an increased frequency of bronchitis and pneumonia early in life." (p. 13)	1984
<b>Pulmonary function (children):</b> "The children of smoking parents appear to have measurable but small differences in tests of pulmonary function when compared with children of nonsmoking parents. The significance of this finding to the future development of lung disease is unknown." (p. 13)	1984
<b>Pulmonary function (adults):</b> ". . .some studies suggest that high levels of involuntary [tobacco] smoke exposure might produce small changes in pulmonary function in normal subjects. . . . Two studies have reported differences in measures of lung function in older populations between subjects chronically exposed to involuntary smoking and those who were not. This difference was not found in a younger and possibly less exposed population." (p. 13)	1984
<b>Acute respiratory infections:</b> "The children of parents who smoke have an increased frequency of a variety of acute respiratory illnesses and infections, including chest illnesses before 2 years of age and physician-diagnosed bronchitis, tracheitis, and laryngitis, when compared with the children of nonsmokers." (p. 13)	1986
<b>Bronchitis and pneumonia:</b> "The children of parents who smoke have an increased frequency of hospitalization for bronchitis and pneumonia during the first year of life when compared with the children of nonsmokers." (p. 13)	1986
<b>Cancers other than lung:</b> "The associations between cancers, other than cancer of the lung, and involuntary smoking require further investigation before a determination can be made about the relationship of involuntary smoking to these cancers." (p. 14)	1986
<b>Cardiovascular disease:</b> "Further studies on the relationship between involuntary smoking and cardiovascular disease are needed in order to determine whether involuntary smoking increases the risk of cardiovascular disease." (p. 14)	1986

Table 1.1 Continued

Disease and statement	Surgeon General's report
<b>Chronic cough and phlegm (children):</b> "Chronic cough and phlegm are more frequent in children whose parents smoke compared with children of nonsmokers." (p. 13)	1986
<b>Chronic obstructive pulmonary disease (COPD):</b> "Healthy adults exposed to environmental tobacco smoke may have small changes on pulmonary function testing, but are unlikely to experience clinically significant deficits in pulmonary function as a result of exposure to environmental tobacco smoke alone." (pp. 13-14)	1986
"The implications of chronic respiratory symptoms for respiratory health as an adult are unknown and deserve further study." (p. 13)	
<b>Lung cancer:</b> "Involuntary smoking can cause lung cancer in nonsmokers." (p. 13)	1986
<b>Middle ear effusions:</b> "A number of studies report that chronic middle ear effusions are more common in young children whose parents smoke than in children of nonsmoking parents." (p. 14)	1986
<b>Pulmonary function (children):</b> "The children of parents who smoke have small differences in tests of pulmonary function when compared with the children of nonsmokers. Although this decrement is insufficient to cause symptoms, the possibility that it may increase susceptibility to chronic obstructive pulmonary disease with exposure to other agents in adult life, e.g., [sic] active smoking or occupational exposures, needs investigation." (p. 13)	1986
<b>Other:</b>	
"An atmosphere contaminated with tobacco smoke can contribute to the discomfort of many individuals." (p. 7)	1972
"Cigarette smoke can make a significant, measurable contribution to the level of indoor air pollution at levels of smoking and ventilation that are common in the indoor environment." (p. 13)	1984
"Cigarette smoke in the air can produce an increase in both subjective and objective measures of eye irritation." (p. 13)	1984
"Nonsmokers who report exposure to environmental tobacco smoke have higher levels of urinary cotinine, a metabolite of nicotine, than those who do not report such exposure." (p. 13)	1984
"The simple separation of smokers and nonsmokers within the same air space may reduce, but does not eliminate, the exposure of nonsmokers to environmental tobacco smoke." (p. 13)	1986
"Validated questionnaires are needed for the assessment of recent and remote exposure to environmental tobacco smoke in the home, workplace, and other environments." (p. 14)	1986

Sources: U.S. Department of Health, Education, and Welfare 1972; U.S. Department of Health and Human Services 1984, 1986.

10  
2-8



patterns of exposure of nonsmokers to tobacco smoke; the epidemiologic evidence on involuntary smoking and disease risks for infants, children, and adults; and policies to control involuntary exposure to tobacco smoke. That report concluded that involuntary smoking caused lung cancer in lifetime nonsmoking adults and was associated with adverse effects on respiratory health in children. The report also stated that simply separating smokers and nonsmokers within the same airspace reduced but did not eliminate exposure to secondhand smoke. All of these findings are relevant to public health and public policy (Table 1.1). The lung cancer conclusion was based on extensive information already available on the carcinogenicity of active smoking, the qualitative similarities between secondhand and mainstream smoke, the uptake of tobacco smoke components by nonsmokers, and the epidemiologic data on involuntary smoking. The three major conclusions of the report (Table 1.2), led Dr. C. Everett Koop, Surgeon General at the time, to comment in his preface that "the right of smokers to smoke ends where their behavior affects the health and well-being of others; furthermore, it is the smokers' responsibility to ensure that they do not expose nonsmokers to the potential [sic] harmful effects of tobacco smoke" (USDHHS 1986, p. xii).

Two other reports published in 1986 also reached the conclusion that involuntary smoking increased the risk for lung cancer. The International Agency for Research on Cancer (IARC) of the World Health Organization concluded that "passive smoking gives rise to some risk of cancer" (IARC 1986, p. 314). In its monograph on tobacco smoking, the agency supported this conclusion on the basis of the characteristics of sidestream and mainstream smoke, the absorption of tobacco smoke materials during an involuntary exposure, and the nature of dose-response

relationships for carcinogenesis. In the same year, the National Research Council (NRC) also concluded that involuntary smoking increases the incidence of lung cancer in nonsmokers (NRC 1986). In reaching this conclusion, the NRC report cited the biologic plausibility of the association between exposure to secondhand smoke and lung cancer and the supporting epidemiologic evidence. On the basis of a pooled analysis of the epidemiologic data adjusted for bias, the report concluded that the best estimate for the excess risk of lung cancer in nonsmokers married to smokers was 25 percent, compared with nonsmokers married to nonsmokers. With regard to the effects of involuntary smoking on children, the NRC report commented on the literature linking secondhand smoke exposures from parental smoking to increased risks for respiratory symptoms and infections and to a slightly diminished rate of lung growth.

Since 1986, the conclusions with regard to both the carcinogenicity of secondhand smoke and the adverse effects of parental smoking on the health of children have been echoed and expanded (Table 1.3). In 1992, the U.S. Environmental Protection Agency (EPA) published its risk assessment of secondhand smoke as a carcinogen (USEPA 1992). The agency's evaluation drew on toxicologic information on secondhand smoke and the extensive literature on active smoking. A comprehensive meta-analysis of the 31 epidemiologic studies of secondhand smoke and lung cancer published up to that time was central to the decision to classify secondhand smoke as a group A carcinogen—namely, a known human carcinogen. Estimates of approximately 3,000 U.S. lung cancer deaths per year in nonsmokers were attributed to secondhand smoke. The report also covered other respiratory health effects in children and adults and concluded that involuntary smoking is causally associated with several adverse

**Table 1.2 Major conclusions of the 1986 Surgeon General's report, *The Health Consequences of Involuntary Smoking***

1. Involuntary smoking is a cause of disease, including lung cancer, in healthy nonsmokers.
2. The children of parents who smoke compared with the children of nonsmoking parents have an increased frequency of respiratory infections, increased respiratory symptoms, and slightly smaller rates of increase in lung function as the lung matures.
3. The simple separation of smokers and nonsmokers within the same air space may reduce, but does not eliminate, the exposure of nonsmokers to environmental tobacco smoke.

Source: U.S. Department of Health and Human Services 1986, p. 7.

11  
2-10

**Table 1.3 Selected major reports, other than those of the U.S. Surgeon General, addressing adverse effects from exposure to tobacco smoke**

Agency	Publication	Place and date of publication
National Research Council	<i>Environmental Tobacco Smoke: Measuring Exposures and Assessing Health Effects</i>	Washington, D.C. United States 1986
International Agency for Research on Cancer (IARC)	<i>Monographs on the Evaluation of the Carcinogenic Risk of Chemicals to Humans: Tobacco Smoking</i> (IARC Monograph 38)	Lyon, France 1986
U.S. Environmental Protection Agency (EPA)	<i>Respiratory Health Effects of Passive Smoking: Lung Cancer and Other Disorders</i>	Washington, D.C. United States 1992
National Health and Medical Research Council	<i>The Health Effects of Passive Smoking</i>	Canberra, Australia 1997
California EPA (Cal/EPA), Office of Environmental Health Hazard Assessment	<i>Health Effects of Exposure to Environmental Tobacco Smoke</i>	Sacramento, California United States 1997
Scientific Committee on Tobacco and Health	<i>Report of the Scientific Committee on Tobacco and Health</i>	London, United Kingdom 1998
World Health Organization	<i>International Consultation on Environmental Tobacco Smoke (ETS) and Child Health. Consultation Report</i>	Geneva, Switzerland 1999
IARC	<i>Tobacco Smoke and Involuntary Smoking</i> (IARC Monograph 83)	Lyon, France 2004
Cal/EPA, Office of Environmental Health Hazard Assessment	<i>Proposed Identification of Environmental Tobacco Smoke as a Toxic Air Contaminant</i>	Sacramento, California United States 2005

respiratory effects in children. There was also a quantitative risk assessment for the impact of involuntary smoking on childhood asthma and lower respiratory tract infections in young children.

In the decade since the 1992 EPA report, scientific panels continued to evaluate the mounting evidence linking involuntary smoking to adverse health effects (Table 1.3). The most recent was the 2005 report of the California EPA (Cal/EPA 2005). Over time, research has repeatedly affirmed the conclusions of the 1986 Surgeon General's reports and studies have further identified causal associations of involuntary smoking with diseases and other health disorders. The epidemiologic evidence on involuntary smoking has markedly expanded since 1986, as have the data on exposure to tobacco smoke in the many environments

where people spend time. An understanding of the mechanisms by which involuntary smoking causes disease has also deepened.

As part of the environmental health hazard assessment, Cal/EPA identified specific health effects causally associated with exposure to secondhand smoke. The agency estimated the annual excess deaths in the United States that are attributable to secondhand smoke exposure for specific disorders: sudden infant death syndrome (SIDS), cardiac-related illnesses (ischemic heart disease), and lung cancer (Cal/EPA 2005). For the excess incidence of other health outcomes, either new estimates were provided or estimates from the 1997 health hazard assessment were used without any revisions (Cal/EPA 1997). Overall, Cal/EPA estimated that about 50,000 excess deaths

result annually from exposure to secondhand smoke (Cal/EPA 2005). Estimated annual excess deaths for the total U.S. population are about 3,400 (a range of 3,423 to 8,866) from lung cancer, 46,000 (a range of 22,700 to 69,600) from cardiac-related illnesses, and 430 from SIDS. The agency also estimated that between 24,300 and 71,900 low birth weight or pre-term deliveries, about 202,300 episodes of childhood asthma (new cases and exacerbations), between 150,000 and 300,000 cases of lower respiratory illness in children, and about 789,700 cases of middle ear infections in children occur each year in the United States as a result of exposure to secondhand smoke.

This new 2006 Surgeon General's report returns to the topic of involuntary smoking. The health effects of involuntary smoking have not received comprehensive coverage in this series of reports since 1986. Reports since then have touched on selected aspects of the topic: the 1994 report on tobacco use among young people (USDHHS 1994), the 1998 report on tobacco use among U.S. racial and ethnic minorities (USDHHS 1998), and the 2001 report on women and smoking (USDHHS 2001). As involuntary smoking remains widespread in the United States and elsewhere, the preparation of this report was motivated by the persistence of involuntary smoking as a public health problem and the need to evaluate the substantial new evidence reported since 1986. This report substantially expands the list of topics that were included in the 1986 report. Additional topics include SIDS, developmental effects, and other reproductive effects; heart disease in adults; and cancer sites beyond the lung. For some associations of involuntary smoking with adverse health effects, only a few studies were reviewed in 1986 (e.g., ear disease in children); now, the relevant literature is substantial. Consequently, this report uses meta-analysis to quantitatively summarize evidence as appropriate. Following the approach used in the 2004 report (*The Health Consequences of Smoking*, USDHHS 2004), this 2006 report also systematically evaluates the evidence for causality, judging the extent of the evidence available and then making an inference as to the nature of the association.

## Organization of the Report

This twenty-ninth report of the Surgeon General examines the topics of toxicology of secondhand smoke, assessment and prevalence of exposure to secondhand smoke, reproductive and developmental health effects, respiratory effects of exposure to

secondhand smoke in children and adults, cancer among adults, cardiovascular diseases, and the control of secondhand smoke exposure.

This introductory chapter (Chapter 1) includes a discussion of the concept of causation and introduces concepts of causality that are used throughout this report; this chapter also summarizes the major conclusions of the report. Chapter 2 (Toxicology of Secondhand Smoke) sets out a foundation for interpreting the observational evidence that is the focus of most of the following chapters. The discussion details the mechanisms that enable tobacco smoke components to injure the respiratory tract and cause nonmalignant and malignant diseases and other adverse effects. Chapter 3 (Assessment of Exposure to Secondhand Smoke) provides a perspective on key factors that determine exposures of people to secondhand smoke in indoor environments, including building designs and operations, atmospheric markers of secondhand smoke, exposure models, and biomarkers of exposure to secondhand smoke. Chapter 4 (Prevalence of Exposure to Secondhand Smoke) summarizes findings that focus on nicotine measurements in the air and cotinine measurements in biologic materials. The chapter includes exposures in the home, workplace, public places, and special populations. Chapter 5 (Reproductive and Developmental Effects from Exposure to Secondhand Smoke) reviews the health effects on reproduction, on infants, and on child development. Chapter 6 (Respiratory Effects in Children from Exposure to Secondhand Smoke) examines the effects of parental smoking on the respiratory health of children. Chapter 7 (Cancer Among Adults from Exposure to Secondhand Smoke) summarizes the evidence on cancer of the lung, breast, nasal sinuses, and the cervix. Chapter 8 (Cardiovascular Diseases from Exposure to Secondhand Smoke) discusses coronary heart disease (CHD), stroke, and subclinical vascular disease. Chapter 9 (Respiratory Effects in Adults from Exposure to Secondhand Smoke) examines odor and irritation, respiratory symptoms, lung function, and respiratory diseases such as asthma and chronic obstructive pulmonary disease. Chapter 10 (Control of Secondhand Smoke Exposure) considers measures used to control exposure to secondhand smoke in public places, including legislation, education, and approaches based on building designs and operations. The report concludes with "A Vision for the Future." Major conclusions of the report were distilled from the chapter conclusions and appear later in this chapter.

## **Preparation of the Report**

This report of the Surgeon General was prepared by the Office on Smoking and Health, National Center for Chronic Disease Prevention and Health Promotion, Coordinating Center for Health Promotion, Centers for Disease Control and Prevention (CDC), and U.S. DHHS. Initial chapters were written by 22 experts who were selected because of their knowledge of a particular topic. The contributions of the initial experts were consolidated into 10 major chapters that were then reviewed by more than 40 peer reviewers. The entire manuscript was then sent to more than 30 scientists and experts who reviewed it for its scientific integrity. After each review cycle, the drafts were revised by the scientific editors on the basis of the experts' comments. Subsequently, the report was reviewed by various institutes and agencies

within U.S. DHHS. Publication lags, even short ones, prevent an up-to-the-minute inclusion of all recently published articles and data. Therefore, by the time the public reads this report, there may be additional published studies or data. To provide published information as current as possible, this report includes an Appendix of more recent studies that represent major additions to the literature.

This report is also accompanied by a companion database of key evidence that is accessible through the Internet (<http://www.cdc.gov/tobacco>). The database includes a uniform description of the studies and results on the health effects of exposure to secondhand smoke that were presented in a format compatible with abstraction into standardized tables. Readers of the report may access these data for additional analyses, tables, or figures.

## **Definitions and Terminology**

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The inhalation of tobacco smoke by nonsmokers has been variably referred to as "passive smoking" or "involuntary smoking." Smokers, of course, also inhale secondhand smoke. Cigarette smoke contains both particles and gases generated by the combustion at high temperatures of tobacco, paper, and additives. The smoke inhaled by nonsmokers that contaminates indoor spaces and outdoor environments has often been referred to as "secondhand smoke" or "environmental tobacco smoke." This inhaled smoke is the mixture of sidestream smoke released by the smoldering cigarette and the mainstream smoke that is exhaled by a smoker. Sidestream smoke, generated at lower temperatures and under somewhat different combustion conditions than mainstream smoke, tends to have higher concentrations of many of the toxins found in cigarette smoke (USDHHS 1986). However, it is rapidly diluted as it travels away from the burning cigarette.

Secondhand smoke is an inherently dynamic mixture that changes in characteristics and concentration with the time since it was formed and the

distance it has traveled. The smoke particles change in size and composition as gaseous components are volatilized and moisture content changes; gaseous elements of secondhand smoke may be adsorbed onto materials, and particle concentrations drop with both dilution in the air or environment and impaction on surfaces, including the lungs or on the body. Because of its dynamic nature, a specific quantitative definition of secondhand smoke cannot be offered.

This report uses the term secondhand smoke in preference to environmental tobacco smoke, even though the latter may have been used more frequently in previous reports. The descriptor "secondhand" captures the involuntary nature of the exposure, while "environmental" does not. This report also refers to the inhalation of secondhand smoke as involuntary smoking, acknowledging that most nonsmokers do not want to inhale tobacco smoke. The exposure of the fetus to tobacco smoke, whether from active smoking by the mother or from her exposure to secondhand smoke, also constitutes involuntary smoking.



## Evidence Evaluation

Following the model of the 1964 report, the Surgeon General's reports on smoking have included comprehensive compilations of the evidence on the health effects of smoking. The evidence is analyzed to identify causal associations between smoking and disease according to enunciated principles, sometimes referred to as the "Surgeon General's criteria" or the "Hill" criteria (after Sir Austin Bradford Hill) for causality (USDHEW 1964; USDHHS 2004). Application of these criteria involves covering all relevant observational and experimental evidence. The criteria, offered in a brief chapter of the 1964 report entitled "Criteria for Judgment," included (1) the consistency of the association, (2) the strength of the association, (3) the specificity of the association, (4) the temporal relationship of the association, and (5) the coherence of the association. Although these criteria have been criticized (e.g., Rothman and Greenland 1998), they have proved useful as a framework for interpreting evidence on smoking and other postulated causes of disease, and for judging whether causality can be inferred.

In the 2004 report of the Surgeon General, *The Health Consequences of Smoking*, the framework for interpreting evidence on smoking and health was revisited in depth for the first time since the 1964 report (USDHHS 2004). The 2004 report provided a four-level hierarchy for interpreting evidence (Table 1.4). The categories acknowledge that evidence can be "suggestive" but not adequate to infer a causal relationship, and also allows for evidence that is "suggestive of no causal relationship." Since the 2004 report, the individual chapter conclusions have consistently used this four-level hierarchy (Table 1.4), but

evidence syntheses and other summary statements may use either the term "increased risk" or "cause" to describe instances in which there is sufficient evidence to conclude that active or involuntary smoking causes a disease or condition. This four-level framework also sharply and completely separates conclusions regarding causality from the implications of such conclusions.

That same framework was used in this report on involuntary smoking and health. The criteria dating back to the 1964 Surgeon General's report remain useful as guidelines for evaluating evidence (USDHEW 1964), but they were not intended to be applied strictly or as a "checklist" that needed to be met before the designation of "causal" could be applied to an association. In fact, for involuntary smoking and health, several of the criteria will not be met for some associations. Specificity, referring to a unique exposure-disease relationship (e.g., the association between thalidomide use during pregnancy and unusual birth defects), can be set aside as not relevant, as all of the health effects considered in this report have causes other than involuntary smoking. Associations are considered more likely to be causal as the strength of an association increases because competing explanations become less plausible alternatives. However, based on knowledge of dosimetry and mechanisms of injury and disease causation, the risk is anticipated to be only slightly or modestly increased for some associations of involuntary smoking with disease, such as lung cancer, particularly when the very strong relative risks found for active smokers are compared with those for lifetime nonsmokers. The finding of only a small elevation in risk, as in the

**Table 1.4** Four-level hierarchy for classifying the strength of causal inferences based on available evidence

Level 1	Evidence is <b>sufficient</b> to infer a causal relationship.
Level 2	Evidence is <b>suggestive but not sufficient</b> to infer a causal relationship.
Level 3	Evidence is <b>inadequate</b> to infer the presence or absence of a causal relationship (which encompasses evidence that is sparse, of poor quality, or conflicting).
Level 4	Evidence is <b>suggestive of no causal relationship</b> .

Source: U.S. Department of Health and Human Services 2004.

example of spousal smoking and lung cancer risk in lifetime nonsmokers, does not weigh against a causal association; however, alternative explanations for a risk of a small magnitude need full exploration and cannot be so easily set aside as alternative explanations for a stronger association. Consistency, coherence, and the temporal relationship of involuntary smoking with disease are central to the interpretations in this report. To address coherence, the report draws not only on the evidence for involuntary smoking, but on the even more extensive literature on active smoking and disease.

Although the evidence reviewed in this report comes largely from investigations of secondhand smoke specifically, the larger body of evidence on active smoking is also relevant to many of the associations that were evaluated. The 1986 report found secondhand smoke to be qualitatively similar to mainstream smoke inhaled by the smoker and concluded that secondhand smoke would be expected to have "a toxic and carcinogenic potential that would

not be expected to be qualitatively different from that of MS [mainstream smoke]" (USDHHS 1986, p. 23). The 2004 report of the Surgeon General revisited the health consequences of active smoking (USDHHS 2004), and the conclusions substantially expanded the list of diseases and conditions caused by smoking. Chapters in the present report consider the evidence on active smoking that is relevant to biologic plausibility for causal associations between involuntary smoking and disease. The reviews included in this report cover evidence identified through search strategies set out in each chapter. Of necessity, the evidence on mechanisms was selectively reviewed. However, an attempt was made to cover all health studies through specified target dates. Because of the substantial amount of time involved in preparing this report, lists of new key references published after these cut-off dates are included in an Appendix. Literature reviews were extended when new evidence was sufficient to possibly change the level of a causal conclusion.

## Major Conclusions

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This report returns to involuntary smoking, the topic of the 1986 Surgeon General's report. Since then, there have been many advances in the research on secondhand smoke, and substantial evidence has been reported over the ensuing 20 years. This report uses the revised language for causal conclusions that was implemented in the 2004 Surgeon General's report (USDHHS 2004). Each chapter provides a comprehensive review of the evidence, a quantitative synthesis of the evidence if appropriate, and a rigorous assessment of sources of bias that may affect interpretations of the findings. The reviews in this report reaffirm and strengthen the findings of the 1986 report. With regard to the involuntary exposure of nonsmokers to tobacco smoke, the scientific evidence now supports the following major conclusions:

1. Secondhand smoke causes premature death and disease in children and in adults who do not smoke.
2. Children exposed to secondhand smoke are at an increased risk for sudden infant death syndrome (SIDS), acute respiratory infections, ear problems, and more severe asthma. Smoking by parents causes respiratory symptoms and slows lung growth in their children.
3. Exposure of adults to secondhand smoke has immediate adverse effects on the cardiovascular system and causes coronary heart disease and lung cancer.
4. The scientific evidence indicates that there is no risk-free level of exposure to secondhand smoke.
5. Many millions of Americans, both children and adults, are still exposed to secondhand smoke in their homes and workplaces despite substantial progress in tobacco control.
6. Eliminating smoking in indoor spaces fully protects nonsmokers from exposure to secondhand smoke. Separating smokers from nonsmokers, cleaning the air, and ventilating buildings cannot eliminate exposures of nonsmokers to secondhand smoke.

16  
2-15

## Chapter Conclusions

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### Chapter 2. Toxicology of Secondhand Smoke

#### *Evidence of Carcinogenic Effects from Secondhand Smoke Exposure*

1. More than 50 carcinogens have been identified in sidestream and secondhand smoke.
2. The evidence is sufficient to infer a causal relationship between exposure to secondhand smoke and its condensates and tumors in laboratory animals.
3. The evidence is sufficient to infer that exposure of nonsmokers to secondhand smoke causes a significant increase in urinary levels of metabolites of the tobacco-specific lung carcinogen 4-(methylnitrosamino)-1-(3-pyridyl)-1-butanone (NNK). The presence of these metabolites links exposure to secondhand smoke with an increased risk for lung cancer.
4. The mechanisms by which secondhand smoke causes lung cancer are probably similar to those observed in smokers. The overall risk of secondhand smoke exposure, compared with active smoking, is diminished by a substantially lower carcinogenic dose.

#### *Mechanisms of Respiratory Tract Injury and Disease Caused by Secondhand Smoke Exposure*

5. The evidence indicates multiple mechanisms by which secondhand smoke exposure causes injury to the respiratory tract.
6. The evidence indicates mechanisms by which secondhand smoke exposure could increase the risk for sudden infant death syndrome.

#### *Mechanisms of Secondhand Smoke Exposure and Heart Disease*

7. The evidence is sufficient to infer that exposure to secondhand smoke has a prothrombotic effect.

8. The evidence is sufficient to infer that exposure to secondhand smoke causes endothelial cell dysfunctions.
9. The evidence is sufficient to infer that exposure to secondhand smoke causes atherosclerosis in animal models.

### Chapter 3. Assessment of Exposure to Secondhand Smoke

#### *Building Designs and Operations*

1. Current heating, ventilating, and air conditioning systems alone cannot control exposure to secondhand smoke.
2. The operation of a heating, ventilating, and air conditioning system can distribute secondhand smoke throughout a building.

#### *Exposure Models*

3. Atmospheric concentration of nicotine is a sensitive and specific indicator for secondhand smoke.
4. Smoking increases indoor particle concentrations.
5. Models can be used to estimate concentrations of secondhand smoke.

#### *Biomarkers of Exposure to Secondhand Smoke*

6. Biomarkers suitable for assessing recent exposures to secondhand smoke are available.
7. At this time, cotinine, the primary proximate metabolite of nicotine, remains the biomarker of choice for assessing secondhand smoke exposure.
8. Individual biomarkers of exposure to secondhand smoke represent only one component of a complex mixture, and measurements of one marker may not wholly reflect an exposure to other components of concern as a result of involuntary smoking.

## Chapter 4. Prevalence of Exposure to Secondhand Smoke

1. The evidence is sufficient to infer that large numbers of nonsmokers are still exposed to secondhand smoke.
2. Exposure of nonsmokers to secondhand smoke has declined in the United States since the 1986 Surgeon General's report, *The Health Consequences of Involuntary Smoking*.
3. The evidence indicates that the extent of secondhand smoke exposure varies across the country.
4. Homes and workplaces are the predominant locations for exposure to secondhand smoke.
5. Exposure to secondhand smoke tends to be greater for persons with lower incomes.
6. Exposure to secondhand smoke continues in restaurants, bars, casinos, gaming halls, and vehicles.

## Chapter 5. Reproductive and Developmental Effects from Exposure to Secondhand Smoke

### *Fertility*

1. The evidence is inadequate to infer the presence or absence of a causal relationship between maternal exposure to secondhand smoke and female fertility or fecundability. No data were found on paternal exposure to secondhand smoke and male fertility or fecundability.

### *Pregnancy (Spontaneous Abortion and Perinatal Death)*

2. The evidence is inadequate to infer the presence or absence of a causal relationship between maternal exposure to secondhand smoke during pregnancy and spontaneous abortion.

### *Infant Deaths*

3. The evidence is inadequate to infer the presence or absence of a causal relationship between exposure to secondhand smoke and neonatal mortality.

### *Sudden Infant Death Syndrome*

4. The evidence is sufficient to infer a causal relationship between exposure to secondhand smoke and sudden infant death syndrome.

### *Preterm Delivery*

5. The evidence is suggestive but not sufficient to infer a causal relationship between maternal exposure to secondhand smoke during pregnancy and preterm delivery.

### *Low Birth Weight*

6. The evidence is sufficient to infer a causal relationship between maternal exposure to secondhand smoke during pregnancy and a small reduction in birth weight.

### *Congenital Malformations*

7. The evidence is inadequate to infer the presence or absence of a causal relationship between exposure to secondhand smoke and congenital malformations.

### *Cognitive Development*

8. The evidence is inadequate to infer the presence or absence of a causal relationship between exposure to secondhand smoke and cognitive functioning among children.

### *Behavioral Development*

9. The evidence is inadequate to infer the presence or absence of a causal relationship between exposure to secondhand smoke and behavioral problems among children.

### *Height/Growth*

10. The evidence is inadequate to infer the presence or absence of a causal relationship between exposure to secondhand smoke and children's height/growth.

### *Childhood Cancer*

11. The evidence is suggestive but not sufficient to infer a causal relationship between prenatal and postnatal exposure to secondhand smoke and childhood cancer.



12. The evidence is inadequate to infer the presence or absence of a causal relationship between maternal exposure to secondhand smoke during pregnancy and childhood cancer.
13. The evidence is inadequate to infer the presence or absence of a causal relationship between exposure to secondhand smoke during infancy and childhood cancer.
14. The evidence is suggestive but not sufficient to infer a causal relationship between prenatal and postnatal exposure to secondhand smoke and childhood leukemias.
15. The evidence is suggestive but not sufficient to infer a causal relationship between prenatal and postnatal exposure to secondhand smoke and childhood lymphomas.
16. The evidence is suggestive but not sufficient to infer a causal relationship between prenatal and postnatal exposure to secondhand smoke and childhood brain tumors.
17. The evidence is inadequate to infer the presence or absence of a causal relationship between prenatal and postnatal exposure to secondhand smoke and other childhood cancer types.

## **Chapter 6. Respiratory Effects in Children from Exposure to Secondhand Smoke**

### *Lower Respiratory Illnesses in Infancy and Early Childhood*

1. The evidence is sufficient to infer a causal relationship between secondhand smoke exposure from parental smoking and lower respiratory illnesses in infants and children.
2. The increased risk for lower respiratory illnesses is greatest from smoking by the mother.

### *Middle Ear Disease and Adenotonsillectomy*

3. The evidence is sufficient to infer a causal relationship between parental smoking and middle ear disease in children, including acute and recurrent otitis media and chronic middle ear effusion.

4. The evidence is suggestive but not sufficient to infer a causal relationship between parental smoking and the natural history of middle ear effusion.
5. The evidence is inadequate to infer the presence or absence of a causal relationship between parental smoking and an increase in the risk of adenoidectomy or tonsillectomy among children.

### *Respiratory Symptoms and Prevalent Asthma in School-Age Children*

6. The evidence is sufficient to infer a causal relationship between parental smoking and cough, phlegm, wheeze, and breathlessness among children of school age.
7. The evidence is sufficient to infer a causal relationship between parental smoking and ever having asthma among children of school age.

### *Childhood Asthma Onset*

8. The evidence is sufficient to infer a causal relationship between secondhand smoke exposure from parental smoking and the onset of wheeze illnesses in early childhood.
9. The evidence is suggestive but not sufficient to infer a causal relationship between secondhand smoke exposure from parental smoking and the onset of childhood asthma.

### *Atopy*

10. The evidence is inadequate to infer the presence or absence of a causal relationship between parental smoking and the risk of immunoglobulin E-mediated allergy in their children.

### *Lung Growth and Pulmonary Function*

11. The evidence is sufficient to infer a causal relationship between maternal smoking during pregnancy and persistent adverse effects on lung function across childhood.
12. The evidence is sufficient to infer a causal relationship between exposure to secondhand smoke after birth and a lower level of lung function during childhood.

## Chapter 7. Cancer Among Adults from Exposure to Secondhand Smoke

### *Lung Cancer*

1. The evidence is sufficient to infer a causal relationship between secondhand smoke exposure and lung cancer among lifetime nonsmokers. This conclusion extends to all secondhand smoke exposure, regardless of location.
2. The pooled evidence indicates a 20 to 30 percent increase in the risk of lung cancer from secondhand smoke exposure associated with living with a smoker.

### *Breast Cancer*

3. The evidence is suggestive but not sufficient to infer a causal relationship between secondhand smoke and breast cancer.

### *Nasal Sinus Cavity and Nasopharyngeal Carcinoma*

4. The evidence is suggestive but not sufficient to infer a causal relationship between secondhand smoke exposure and a risk of nasal sinus cancer among nonsmokers.
5. The evidence is inadequate to infer the presence or absence of a causal relationship between secondhand smoke exposure and a risk of nasopharyngeal carcinoma among nonsmokers.

### *Cervical Cancer*

6. The evidence is inadequate to infer the presence or absence of a causal relationship between secondhand smoke exposure and the risk of cervical cancer among lifetime nonsmokers.

## Chapter 8. Cardiovascular Diseases from Exposure to Secondhand Smoke

1. The evidence is sufficient to infer a causal relationship between exposure to secondhand smoke and increased risks of coronary heart disease morbidity and mortality among both men and women.
2. Pooled relative risks from meta-analyses indicate a 25 to 30 percent increase in the risk of coronary

heart disease from exposure to secondhand smoke.

3. The evidence is suggestive but not sufficient to infer a causal relationship between exposure to secondhand smoke and an increased risk of stroke.
4. Studies of secondhand smoke and subclinical vascular disease, particularly carotid arterial wall thickening, are suggestive but not sufficient to infer a causal relationship between exposure to secondhand smoke and atherosclerosis.

## Chapter 9. Respiratory Effects in Adults from Exposure to Secondhand Smoke

### *Odor and Irritation*

1. The evidence is sufficient to infer a causal relationship between secondhand smoke exposure and odor annoyance.
2. The evidence is sufficient to infer a causal relationship between secondhand smoke exposure and nasal irritation.
3. The evidence is suggestive but not sufficient to conclude that persons with nasal allergies or a history of respiratory illnesses are more susceptible to developing nasal irritation from secondhand smoke exposure.

### *Respiratory Symptoms*

4. The evidence is suggestive but not sufficient to infer a causal relationship between secondhand smoke exposure and acute respiratory symptoms including cough, wheeze, chest tightness, and difficulty breathing among persons with asthma.
5. The evidence is suggestive but not sufficient to infer a causal relationship between secondhand smoke exposure and acute respiratory symptoms including cough, wheeze, chest tightness, and difficulty breathing among healthy persons.
6. The evidence is suggestive but not sufficient to infer a causal relationship between secondhand smoke exposure and chronic respiratory symptoms.

*Lung Function*

7. The evidence is suggestive but not sufficient to infer a causal relationship between short-term secondhand smoke exposure and an acute decline in lung function in persons with asthma.
8. The evidence is inadequate to infer the presence or absence of a causal relationship between short-term secondhand smoke exposure and an acute decline in lung function in healthy persons.
9. The evidence is suggestive but not sufficient to infer a causal relationship between chronic secondhand smoke exposure and a small decrement in lung function in the general population.
10. The evidence is inadequate to infer the presence or absence of a causal relationship between chronic secondhand smoke exposure and an accelerated decline in lung function.

*Asthma*

11. The evidence is suggestive but not sufficient to infer a causal relationship between secondhand smoke exposure and adult-onset asthma.
12. The evidence is suggestive but not sufficient to infer a causal relationship between secondhand smoke exposure and a worsening of asthma control.

*Chronic Obstructive Pulmonary Disease*

13. The evidence is suggestive but not sufficient to infer a causal relationship between secondhand smoke exposure and risk for chronic obstructive pulmonary disease.
14. The evidence is inadequate to infer the presence or absence of a causal relationship between secondhand smoke exposure and morbidity in persons with chronic obstructive pulmonary disease.

**Chapter 10. Control of Secondhand Smoke Exposure**

1. Workplace smoking restrictions are effective in reducing secondhand smoke exposure.
2. Workplace smoking restrictions lead to less smoking among covered workers.
3. Establishing smoke-free workplaces is the only effective way to ensure that secondhand smoke exposure does not occur in the workplace.
4. The majority of workers in the United States are now covered by smoke-free policies.
5. The extent to which workplaces are covered by smoke-free policies varies among worker groups, across states, and by sociodemographic factors. Workplaces related to the entertainment and hospitality industries have notably high potential for secondhand smoke exposure.
6. Evidence from peer-reviewed studies shows that smoke-free policies and regulations do not have an adverse economic impact on the hospitality industry.
7. Evidence suggests that exposure to secondhand smoke varies by ethnicity and gender.
8. In the United States, the home is now becoming the predominant location for exposure of children and adults to secondhand smoke.
9. Total bans on indoor smoking in hospitals, restaurants, bars, and offices substantially reduce secondhand smoke exposure, up to several orders of magnitude with incomplete compliance, and with full compliance, exposures are eliminated.
10. Exposures of nonsmokers to secondhand smoke cannot be controlled by air cleaning or mechanical air exchange.

## Methodologic Issues

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Much of the evidence on the health effects of involuntary smoking comes from observational epidemiologic studies that were carried out to test hypotheses related to secondhand smoke and risk for diseases and other adverse health effects. The challenges faced in carrying out these studies reflect those of observational research generally: assessment of the relevant exposures and outcomes with sufficient validity and precision, selection of an appropriate study design, identification of an appropriate and sufficiently large study population, and collection of information on other relevant factors that may confound or modify the association being studied. The challenge of accurately classifying secondhand smoke exposures confronts all studies of such exposures, and consequently the literature on approaches to and limitations of exposure classification is substantial. Sources of bias that can affect the findings of epidemiologic studies have been widely discussed (Rothman and Greenland 1998), both in general and in relation to studies of involuntary smoking. Concerns about bias apply to any study of an environmental agent and disease risk: misclassification of exposures or outcomes, confounding effect modification, and proper selection of study participants. In addition, the generalizability of findings from one population to another (external validity) further determines the value of evidence from a study. Another methodologic concern affecting secondhand smoke literature comes from the use of meta-analysis to combine the findings of epidemiologic studies; general concerns related to the use of meta-analysis for observational data and more specific concerns related to involuntary smoking have also been raised. This chapter considers these methodologic issues in anticipation of more specific treatment in the following chapters.

### Classification of Secondhand Smoke Exposure

For secondhand smoke, as for any environmental factor that may be a cause of disease, the exposure assessment might encompass the time and place of the exposure, cumulative exposures, exposure during a particular time, or a recent exposure (Jaakkola and Jaakkola 1997; Jaakkola and Samet 1999). For example, exposures to secondhand smoke across the full life

span may be of interest for lung cancer, while only more recent exposures may be relevant to the exacerbation of asthma. For CHD, both temporally remote and current exposures may affect risk. Assessments of exposures are further complicated by the multiplicity of environments where exposures take place and the difficulty of characterizing the exposure in some locations, such as public places or workplaces. Additionally, exposures probably vary qualitatively and quantitatively over time and across locations because of temporal changes and geographic differences in smoking patterns.

Nonetheless, researchers have used a variety of approaches for exposure assessments in epidemiologic studies of adverse health effects from involuntary smoking. Several core concepts that are fundamental to these approaches are illustrated in Figure 1.1 (Samet and Jaakkola 1999). Cigarette smoking is, of course, the source of most secondhand smoke in the United States, followed by pipes, cigars, and other products. Epidemiologic studies generally focus on assessing the exposure, which is the contact with secondhand smoke. The concentrations of secondhand smoke components in a space depend on the number of smokers and the rate at which they are smoking, the volume into which the smoke is distributed, the rate at which the air in the space exchanges with uncontaminated air, and the rate at which the secondhand smoke is removed from the air. Concentration, exposure, and dose differ in their definitions, although the terms are sometimes used without sharp distinctions. However, surrogate indicators that generally describe a source of exposure may also be used to assess the exposure, such as marriage to a smoker or the number of cigarettes smoked in the home. Biomarkers can provide an indication of an exposure or possibly the dose, but for secondhand smoke they are used for recent exposure only.

People are exposed to secondhand smoke in a number of different places, often referred to as "microenvironments" (NRC 1991). A microenvironment is a definable location that has a constant concentration of the contaminant of interest, such as secondhand smoke, during the time that a person is there. Some key microenvironments for secondhand smoke include the home, the workplace, public places, and transportation environments (Klepeis 1999). Based





over recent days or, at most, weeks. Questionnaires on secondhand smoke exposure have been assessed for their reliability and validity, generally based on comparisons with either biomarker or air monitoring data as the "gold" standard (Jaakkola and Jaakkola 1997). Two studies evaluated the reliability of questionnaires on lifetime exposures (Pron et al. 1988; Coultas et al. 1989). Both showed a high degree of repeatability for questions concerning whether a spouse had smoked, but a lower reliability for responses concerning the quantitative aspects of an exposure. Emerson and colleagues (1995) evaluated the repeatability of information from parents of children with asthma. They found a high reliability for parent-reported tobacco use and for the number of cigarettes to which the child was exposed in the home during the past week.

To assess validity, questionnaire reports of current or recent exposures have been compared with levels of cotinine and other biomarkers. These studies tend to show a moderate correlation between levels of cotinine and questionnaire indicators of exposures (Kawachi and Colditz 1996; Cal/EPA 1997; Jaakkola and Jaakkola 1997). However, cotinine levels reflect not only exposure but metabolism and excretion (Benowitz 1999). Consequently, exposure is only one determinant of variation in cotinine levels among persons; there also are individual variations in metabolism and excretion rates. In spite of these sources of variability, mean levels of cotinine vary as anticipated across categories of self-reported exposures (Cal/EPA 1997; Jaakkola and Jaakkola 1997), and self-reported exposures are moderately associated with measured levels of markers (Cal/EPA 1997; Jaakkola and Jaakkola 1997).

Biomarkers are also used for assessing exposures to secondhand smoke. A number of biomarkers are available, but they vary in their specificity and in the dynamics of the temporal relationship between the exposure and the marker level (Cal/EPA 1997; Benowitz 1999). These markers include specific tobacco smoke components (nicotine) or metabolites (cotinine and tobacco-specific nitrosamines), nonspecific biomarkers (thiocyanate and CO), adducts with tobacco smoke components or metabolites (4-aminobiphenyl-hemoglobin adducts, benzo[*a*]pyrene-DNA adducts, and polycyclic aromatic hydrocarbon-albumin adducts), and nonspecific assays (urinary mutagenicity). Cotinine has been the most widely used biomarker, primarily because of its specificity, half-life, and ease of measurement in body fluids (e.g., urine, blood, and saliva). Biomarkers are discussed

in detail in Chapter 3 (Assessment of Exposure to Secondhand Smoke).

Some epidemiologic studies have also incorporated air monitoring, either direct personal sampling or the indirect approach based on the microenvironmental model. Nicotine, present in the gas phase of secondhand smoke, can be monitored passively with a special filter or actively using a pump and a sorbent. Hammond and Leaderer (1987) first described a diffusion monitor for the passive sampling of nicotine in 1987; this device has now been widely used to assess concentrations in different environments and to study health effects. Airborne particles have also been measured using active monitoring devices.

Each of these approaches for assessing exposures has strengths and limitations, and preference for one over another will depend on the research question and its context (Jaakkola and Jaakkola 1997; Jaakkola and Samet 1999). Questionnaires can be used to characterize sources of exposures, such as smoking by parents. With air concentrations of markers and time-activity information, estimates of secondhand smoke exposures can be made with the microenvironmental model. Biomarkers provide exposure measures that reflect the patterns of exposure and the kinetics of the marker; the cotinine level in body fluids, for example, reflects an exposure during several days. Air monitoring may be useful for validating measurements of exposure. Exposure assessment strategies are matched to the research question and often employ a mixture of approaches determined by feasibility and cost constraints.

### Misclassification of Secondhand Smoke Exposure

Misclassification may occur when classifying exposures, outcomes, confounding factors, or modifying factors. Misclassification may be differential on either exposure or outcome, or it may be random (Armstrong et al. 1992). Differential or nonrandom misclassification may either increase or decrease estimates of effect, while random misclassification tends to reduce the apparent effect and weaken the relationship of exposure with disease risk. In studies of secondhand smoke and disease risk, exposure misclassification has been a major consideration in the interpretation of the evidence, although misclassification of health outcome measures has not been a substantial issue in this research. The consequences for epidemiologic studies of misclassification in general are well established (Rothman and Greenland 1998).

An extensive body of literature on the classification of exposures to secondhand smoke is reviewed in this and other chapters, as well as in some publications on the consequences of misclassification (Wu 1999). Two general patterns of exposure misclassification are of concern to secondhand smoke: (1) random misclassification that is not differential by the presence or absence of the health outcome and (2) systematic misclassification that is differential by the health outcome. In studying the health effects of secondhand smoke in adults, there is a further concern as to the classification of the active smoking status (never, current, or former smoking); in studies of children, the accuracy of secondhand smoke exposure classification is the primary methodologic issue around exposure assessment, but unreported active smoking by adolescents is also a concern.

With regard to random misclassification of secondhand smoke exposures, there is an inherent degree of unavoidable measurement error in the exposure measures used in epidemiologic studies. Questionnaires generally assess contact with sources of an exposure (e.g., smoking in the home or workplace) and cannot capture all exposures nor the intensity of exposures; biomarkers provide an exposure index for a particular time window and have intrinsic variability. Some building-related factors that determine an exposure cannot be assessed accurately by a questionnaire, such as the rate of air exchange and the size of the microenvironment where time is spent, nor can concentrations be assessed accurately by subjective reports of the perceived level of tobacco smoke. In general, random misclassification of exposures tends to reduce the likelihood that studies of secondhand smoke exposure will find an effect. This type of misclassification lessens the contrast between exposure groups, because some truly exposed persons are placed in the unexposed group and some truly unexposed persons are placed in the exposed group. Differential misclassification, also a concern, may increase or decrease associations, depending on the pattern of misreporting.

One particular form of misclassification has been raised with regard to secondhand smoke exposure and lung cancer: the classification of some current or former smokers as lifetime nonsmokers (USEPA 1992; Lee and Forey 1995; Hackshaw et al. 1997; Wu 1999). The resulting bias would tend to increase the apparent association of secondhand smoke with lung cancer, if the misclassified active smokers are also more likely to be classified as involuntary smokers. Most studies of lung cancer and secondhand smoke have used spousal smoking as a main exposure variable. As

smoking tends to aggregate between spouses (smokers are more likely to marry smokers), misclassification of active smoking would tend to be differential on the basis of spousal smoking (the exposure under investigation). Because active smoking is strongly associated with increased disease risk, greater misclassification of an actively smoking spouse as a nonsmoker among spouses of smokers compared with spouses of nonsmokers would lead to risk estimates for spousal smoking that are biased upward by the effect of active smoking. This type of misclassification is also relevant to studies of spousal exposure and CHD risk or other diseases also caused by active smoking, although the potential for bias is less because the association of active smoking with CHD is not as strong as with lung cancer.

There have been a number of publications on this form of misclassification. Wu (1999) provides a review, and Lee and colleagues (2001) offer an assessment of potential consequences. A number of models have been developed to assess the extent of bias resulting from the misclassification of active smokers as lifetime nonsmokers (USEPA 1992; Hackshaw et al. 1997). These models incorporate estimates of the rate of misclassification, the degree of aggregation of smokers by marriage, the prevalence of smoking in the population, and the risk of lung cancer in misclassified smokers (Wu 1999). Although debate about this issue continues, analyses show that estimates of upward bias from misclassifying active smokers as lifetime nonsmokers cannot fully explain the observed increase in risk for lung cancer among lifetime nonsmokers married to smokers (Hackshaw et al. 1997; Wu 1999).

There is one additional issue related to exposure misclassification. During the time the epidemiologic studies of secondhand smoke have been carried out, exposure has been widespread and almost unavoidable. Therefore, the risk estimates may be biased downward because there are no truly unexposed persons. The 1986 Surgeon General's report recognized this methodologic issue and noted the need for further data on population exposures to secondhand smoke (USDHHS 1986). This bias was also recognized in the 1986 report of the NRC, and an adjustment for this misclassification was made to the lung cancer estimate (NRC 1986). Similarly, the 1992 report of the EPA commented on background exposure and made an adjustment (USEPA 1992). Some later studies have attempted to address this issue; for example, in a case-control study of active and involuntary smoking and breast cancer in Switzerland, Morabia and colleagues (2000) used a questionnaire to assess exposure and

25  
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identified a small group of lifetime nonsmokers who also reported no exposure to secondhand smoke. With this subgroup of controls as the reference population, the risks of secondhand smoke exposure were substantially greater for active smoking than when the full control population was used.

This Surgeon General's report further addresses specific issues of exposure misclassification when they are relevant to the health outcome under consideration.

### Use of Meta-Analysis

Meta-analysis refers to the process of evaluating and combining a body of research literature that addresses a common question. Meta-analysis is composed of qualitative and quantitative components. The qualitative component involves the systematic identification of all relevant investigations, a systematic assessment of their characteristics and quality, and the decision to include or exclude studies based on predetermined criteria. Consideration can be directed toward sources of bias that might affect the findings. The quantitative component involves the calculation and display of study results on common scales and, if appropriate, the statistical combination of these results across studies and an exploration of the reasons for any heterogeneity of findings. Viewing the findings of all studies as a single plot provides insights into the consistency of results and the precision of the studies considered. Most meta-analyses are based on published summary results, although they are most powerful when applied to data at the level of individual participants. Meta-analysis is most widely used to synthesize evidence from randomized clinical trials, sometimes yielding findings that were not evident from the results of individual studies. Meta-analysis also has been used extensively to examine bodies of observational evidence.

Beginning with the 1986 NRC report, meta-analysis has been used to summarize the evidence on involuntary smoking and health. Meta-analysis was central to the 1992 EPA risk assessment of secondhand smoke, and a series of meta-analyses supported the conclusions of the 1998 report of the Scientific Committee on Tobacco and Health in the United Kingdom. The central role of meta-analysis in interpreting and applying the evidence related to involuntary smoking and disease has led to focused criticisms of the use of meta-analysis in this context. Several papers that acknowledged support from the tobacco industry have addressed the epidemiologic findings for lung cancer, including the selection and quality of the

studies, the methods for meta-analysis, and dose-response associations (Fleiss and Gross 1991; Tweedie and Mengersen 1995; Lee 1998, 1999). In a lawsuit brought by the tobacco industry against the EPA, the 1998 decision handed down by Judge William L. Osteen, Sr., in the North Carolina Federal District Court criticized the approach EPA had used to select studies for its meta-analysis and criticized the use of 90 percent rather than 95 percent confidence intervals for the summary estimates (*Flue-Cured Tobacco Cooperative Stabilization Corp. v. United States Environmental Protection Agency*, 857 F. Supp. 1137 [M.D.N.C. 1993]). In December 2002, the 4th U.S. Circuit Court of Appeals threw out the lawsuit on the basis that tobacco companies cannot sue the EPA over its secondhand smoke report because the report was not a final agency action and therefore not subject to court review (*Flue-Cured Tobacco Cooperative Stabilization Corp. v. The United States Environmental Protection Agency*, No. 98-2407 [4th Cir., December 11, 2002], cited in 17.7 TPLR 2.472 [2003]).

Recognizing that there is still an active discussion around the use of meta-analysis to pool data from observational studies (versus clinical trials), the authors of this Surgeon General's report used this methodology to summarize the available data when deemed appropriate and useful, even while recognizing that the uncertainty around the meta-analytic estimates may exceed the uncertainty indicated by conventional statistical indices, because of biases either within the observational studies or produced by the manner of their selection. However, a decision to not combine estimates might have produced conclusions that are far more uncertain than the data warrant because the review would have focused on individual study results without considering their overall pattern, and without allowing for a full accounting of different sample sizes and effect estimates.

The possibility of publication bias has been raised as a potential limitation to the interpretation of evidence on involuntary smoking and disease in general, and on lung cancer and secondhand smoke exposure specifically. A 1988 paper by Vandembroucke used a descriptive approach, called a "funnel plot," to assess the possibility that publication bias affected the 13 studies considered in a review by Wald and colleagues (1986). This type of plot characterizes the relationship between the magnitude of estimates and their precision. Vandembroucke suggested the possibility of publication bias only in reference to the studies of men. Bero and colleagues (1994) concluded that there

26  
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had not been a publication bias against studies with statistically significant findings, nor against the publication of studies with nonsignificant or mixed findings in the research literature. The researchers were able to identify only five unpublished "negative" studies, of which two were dissertations that tend to be delayed in publication. A subsequent study by Misakian and Bero (1998) did find a delay in the publication of studies with nonsignificant results in comparison with studies having significant results; whether this pattern has varied over the several decades of research on secondhand smoke was not addressed. More recently, Copas and Shi (2000) assessed the 37 studies considered in the meta-analysis by Hackshaw and colleagues (1997) for publication bias. Copas and Shi (2000) found a significant correlation between the estimated risk of exposure and sample size, such that smaller studies tended to have higher values. This pattern suggests the possibility of publication bias. However, using a funnel plot of the same studies, Lubin (1999) found little evidence for publication bias.

On this issue of publication bias, it is critical to distinguish between indirect statistical arguments and arguments based on actual identification of previously unidentified research. The strongest case against substantive publication bias has been made by researchers who mounted intensive efforts to find the possibly missing studies; these efforts have yielded little—nothing that would alter published conclusions (Bero et al. 1994; Glantz 2000). Presumably because this exposure is a great public health concern, the findings of studies that do not have statistically significant outcomes continue to be published (Kawachi and Colditz 1996).

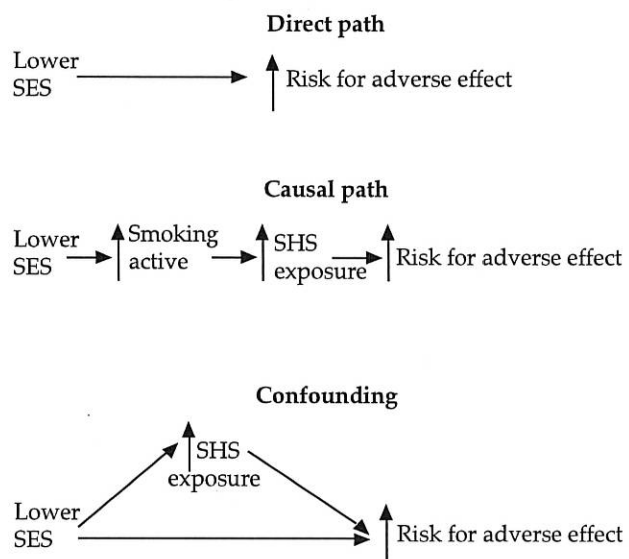
The quantitative results of the meta-analyses, however, were not determinate in making causal inferences in this Surgeon General's report. In particular, the level of statistical significance of estimates from the meta-analyses was not a predominant factor in making a causal conclusion. For that purpose, this report relied on the approach and criteria set out in the 1964 and 2004 reports of the Surgeon General, which involved judgments based on an array of quantitative and qualitative considerations that included the degree of heterogeneity in the designs of the studies that were examined. Sometimes this heterogeneity limits the inference from meta-analysis by weakening the rationale for pooling the study results. However, the availability of consistent evidence from heterogeneous designs can strengthen the meta-analytic findings by making it unlikely that a common bias could persist across different study designs and populations.

## Confounding

Confounding, which refers in this context to the mixing of the effect of another factor with that of secondhand smoke, has been proposed as an explanation for associations of secondhand smoke with adverse health consequences. Confounding occurs when the factor of interest (secondhand smoke) is associated in the data under consideration with another factor (the confounder) that, by itself, increases the risk for the disease (Rothman and Greenland 1998). Correlates of secondhand smoke exposures are not confounding factors unless an exposure to them increases the risk of disease. A factor proposed as a potential confounder is not necessarily an actual confounder unless it fulfills the two elements of the definition. Although lengthy lists of potential confounding factors have been offered as alternatives to direct associations of secondhand smoke exposures with the risk for disease, the factors on these lists generally have not been shown to be confounding in the particular data of interest.

The term confounding also conveys an implicit conceptualization as to the causal pathways that link secondhand smoke and the confounding factor to

**Figure 1.2 Model for socioeconomic status (SES) and secondhand smoke (SHS) exposure**



Arrows indicate directionality of association.

27  
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disease risk. Confounding implies that the confounding factor has an effect on risk that is independent of secondhand smoke exposure. Some factors considered as potential confounders may, however, be in the same causal pathway as a secondhand smoke exposure. Although socioeconomic status (SES) is often cited as a potential confounding factor, it may not have an independent effect but can affect disease risk through its association with secondhand smoke exposure (Figure 1.2). This figure shows general alternative relationships among SES, secondhand smoke exposure, and risk for an adverse effect. SES may have a direct effect, or it may indirectly exert its effect through an association with secondhand smoke exposure, or it may confound the relationship between secondhand smoke exposure and disease risk. To control for SES as a potential confounding factor without considering underlying relationships may lead to incorrect risk estimates. For example, controlling for SES would not be appropriate if it is a determinant of secondhand smoke exposure but has no direct effect.

Nonetheless, because the health effects of involuntary smoking have other causes, the possibility of confounding needs careful exploration when assessing associations of secondhand smoke exposure with adverse health effects. In addition, survey data from

the last several decades show that secondhand smoke exposure is associated with correlates of lifestyle that may influence the risk for some health effects, thus increasing concerns for the possibility of confounding (Kawachi and Colditz 1996). Survey data from the United States (Matanoski et al. 1995) and the United Kingdom (Thornton et al. 1994) show that adults with secondhand smoke exposures generally tend to have less healthful lifestyles. However, the extent to which these patterns of association can be generalized, either to other countries or to the past, is uncertain.

The potential bias from confounding varies with the association of the confounder to secondhand smoke exposures in a particular study and to the strength of the confounder as a risk factor. The importance of confounding to the interpretation of evidence depends further on the magnitude of the effect of secondhand smoke on disease. As the strength of an association lessens, confounding as an alternative explanation for an association becomes an increasing concern. In prior reviews, confounding has been addressed either quantitatively (Hackshaw et al. 1997) or qualitatively (Cal/EPA 1997; Thun et al. 1999). In the chapters in this report that focus on specific diseases, confounding is specifically addressed in the context of potential confounding factors for the particular diseases.

## Tobacco Industry Activities

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The evidence on secondhand smoke and disease risk, given the public health and public policy implications, has been reviewed extensively in the published peer-reviewed literature and in evaluations by a number of expert panels. In addition, the evidence has been criticized repeatedly by the tobacco industry and its consultants in venues that have included the peer-reviewed literature, public meetings and hearings, and scientific symposia that included symposia sponsored by the industry. Open criticism in the peer-reviewed literature can strengthen the credibility of scientific evidence by challenging researchers to consider the arguments proposed by critics and to rebut them.

Industry documents indicate that the tobacco industry has engaged in widespread activities, however, that have gone beyond the bounds of accepted scientific practice (Glantz 1996; Ong and Glantz 2000, 2001; Rampton and Stauber 2000; Yach and Bialous

2001; Hong and Bero 2002; Diethelm et al. 2004). Through a variety of organized tactics, the industry has attempted to undermine the credibility of the scientific evidence on secondhand smoke. The industry has funded or carried out research that has been judged to be biased, supported scientists to generate letters to editors that criticized research publications, attempted to undermine the findings of key studies, assisted in establishing a scientific society with a journal, and attempted to sustain controversy even as the scientific community reached consensus (Garne et al. 2005). These tactics are not a topic of this report, but to the extent that the scientific literature has been distorted, they are addressed as the evidence is reviewed. This report does not specifically identify tobacco industry sponsorship of publications unless that information is relevant to the interpretation of the findings and conclusions.

## A Vision for the Future

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This country has experienced a substantial reduction of involuntary exposure to secondhand tobacco smoke in recent decades. Significant reductions in the rate of smoking among adults began even earlier. Consequently, about 80 percent of adults are now nonsmokers, and many adults and children can live their daily lives without being exposed to secondhand smoke. Nevertheless, involuntary exposure to secondhand smoke remains a serious public health hazard.

This report documents the mounting and now substantial evidence characterizing the health risks caused by exposure to secondhand smoke. Multiple major reviews of the evidence have concluded that secondhand smoke is a known human carcinogen, and that exposure to secondhand smoke causes adverse effects, particularly on the cardiovascular system and the respiratory tract and on the health of those exposed, children as well as adults. Unfortunately, reductions in exposure have been slower among young children than among adults during the last decade, as expanding workplace restrictions now protect the majority of adults while homes remain the most important source of exposure for children.

Clearly, the social norms regarding secondhand smoke have changed dramatically, leading to widespread support over the past 30 years for a society free of involuntary exposures to tobacco smoke. In the first half of the twentieth century smoking was permitted in almost all public places, including elevators and all types of public transportation. At the time of the 1964 Surgeon General's report on smoking and health (U.S. Department of Health, Education, and Welfare [USDHEW] 1964), many physicians were still smokers, and the tables in U.S. Public Health Service (PHS) meeting rooms had PHS ashtrays on them. A thick, smoky haze was an accepted part of presentations at large meetings, even at medical conferences and in the hospital environment.

As the adverse health consequences of active smoking became more widely documented in the 1960s, many people began to question whether exposure of nonsmokers to secondhand smoke also posed a serious health risk. This topic was first addressed in this series of reports by Surgeon General Jesse Steinfeld in the 1972 report to Congress (USDHEW 1972). During the 1970s, policy changes to provide smoke-free environments received more widespread

consideration. As the public policy debate grew and expanded in the 1980s, the scientific evidence on the risk of adverse effects from exposure to secondhand smoke was presented in a comprehensive context for the first time by Surgeon General C. Everett Koop in the 1986 report, *The Health Consequences of Involuntary Smoking* (U.S. Department of Health and Human Services [USDHHS] 1986).

The ever-increasing momentum for smoke-free indoor environments has been driven by scientific evidence on the health risks of involuntary exposure to secondhand smoke. This new Surgeon General's report is based on a far larger body of evidence than was available in 1986. The evidence reviewed in this report confirms the findings of the 1986 report and adds new causal conclusions. The growing body of data increases support for the conclusion that exposure to secondhand smoke causes lung cancer in lifetime nonsmokers. In addition to epidemiologic data, this report presents converging evidence that the mechanisms by which secondhand smoke causes lung cancer are similar to those that cause lung cancer in active smokers. In the context of the risks from active smoking, the lung cancer risk that secondhand smoke exposure poses to nonsmokers is consistent with an extension to involuntary smokers of the dose-response relationship for active smokers.

Cardiovascular effects of even short exposures to secondhand smoke are readily measurable, and the risks for cardiovascular disease from involuntary smoking appear to be about 50 percent less than the risks for active smokers. Although the risks from secondhand smoke exposures are larger than anticipated, research on the mechanisms by which tobacco smoke exposure affects the cardiovascular system supports the plausibility of the findings of epidemiologic studies (the 1986 report did not address cardiovascular disease). This 2006 report also reviews the evidence on the multiple mechanisms by which secondhand smoke injures the respiratory tract and causes sudden infant death syndrome.

Since 1986, the attitude of the public toward and the social norms around secondhand smoke exposure have changed dramatically to reflect a growing viewpoint that the involuntary exposure of nonsmokers to secondhand smoke is unacceptable. As a result, increasingly strict public policies to control involuntary exposure to secondhand smoke have been put in

place. The need for restrictions on smoking in enclosed public places is now widely accepted in the United States. A growing number of communities, counties, and states are requiring smoke-free environments for nearly all enclosed public places, including all private worksites, restaurants, bars, and casinos.

As knowledge about the health risks of secondhand smoke exposure grows, investigators continue to identify additional scientific questions.

- Because active smoking is firmly established as a causal factor of cancer for a large number of sites, and because many scientists assert that there may be no threshold for carcinogenesis from tobacco smoke exposure, researchers hypothesize that people who are exposed to secondhand smoke are likely to be at some risk for the same types of cancers that have been established as smoking-related among active smokers.
- The potential risks for stroke and subclinical vascular disease from secondhand smoke exposure require additional research.
- There is a need for additional research on the etiologic relationship between secondhand smoke exposure and several respiratory health outcomes in adults, including respiratory symptoms, declines in lung function, and adult-onset asthma.
- There is also a need for research to further evaluate the adverse reproductive outcomes and childhood respiratory effects from both prenatal and postnatal exposure to secondhand smoke.
- Further research and improved methodologies are also needed to advance an understanding of the potential effects on cognitive, behavioral, and physical development that might be related to early exposures to secondhand smoke.

As these and other research questions are addressed, the scientific literature documenting the adverse health effects of exposure to secondhand smoke will expand. Over the past 40 years since the release of the landmark 1964 report of the Surgeon General's Advisory Committee on Smoking and Health (USDHEW 1964), researchers have compiled an ever-growing list of adverse health effects caused by exposure to tobacco smoke, with evidence that active smoking causes damage to virtually every organ of

the body (USDHHS 2004). Similarly, since the 1986 report (USDHHS 1986), the number of adverse health effects caused by exposure to secondhand smoke has also expanded. Following the format of the electronic database released with the 2004 report, the research findings supporting the conclusions in this report will be accessible in a database that can be found at <http://www.cdc.gov/tobacco>. With an this expanding base of scientific knowledge, the list of adverse health effects caused by exposure to secondhand smoke will likely increase.

Biomarker data from the 2005 *Third National Report on Human Exposure to Environmental Chemicals* document great progress since the 1986 report in reducing the involuntary exposure of nonsmokers to secondhand smoke (CDC 2005). Between the late 1980s and 2002, the median cotinine level (a metabolite of nicotine) among nonsmokers declined by more than 70 percent. Nevertheless, many challenges remain to maintain the momentum toward universal smoke-free environments. First, there is a need to continue and even improve the surveillance of sources and levels of exposure to secondhand smoke. The data from the 2005 exposure report show that median cotinine levels among children are more than twice those of nonsmoking adults, and non-Hispanic Blacks have levels more than twice those of Mexican Americans and non-Hispanic Whites (CDC 2005). The multiple factors related to these disparities in median cotinine levels among nonsmokers need to be identified and addressed. Second, the data from the 2005 exposure report suggest that the scientific community should sustain the current momentum to reduce exposures of nonsmokers to secondhand smoke (CDC 2005). Research reviewed in this report indicates that policies creating completely smoke-free environments are the most economical and efficient approaches to providing this protection. Additionally, neither central heating, ventilating, and air conditioning systems nor separately ventilated rooms control exposures to secondhand smoke. Unfortunately, data from the 2005 exposure report also emphasized that young children remain an exposed population (CDC 2005). However, more evidence is needed on the most effective strategies to promote voluntary changes in smoking norms and practices in homes and private automobiles. Finally, data on the health consequences of secondhand smoke exposures emphasize the importance of the role of health care professionals in this issue. They must assume a greater, more active involvement in reducing exposures, particularly for susceptible groups.



The findings and recommendations of this report can be extended to other countries and are supportive of international efforts to address the health effects of smoking and secondhand smoke exposure. There is an international consensus that exposure to secondhand smoke poses significant public health risks. The Framework Convention on Tobacco Control recognizes that protecting nonsmokers from involuntary exposures to secondhand smoke in public places should be an integral part of comprehensive national tobacco control policies and programs. Recent changes in national policies in countries such as Italy and Ireland reflect this growing international awareness of the need for additional protection of nonsmokers from involuntary exposures to secondhand smoke.

When this series of reports began in 1964, the majority of men and a substantial proportion of women were smokers, and most nonsmokers inevitably must have been involuntary smokers. With the release of the 1986 report, Surgeon General Koop noted that "the right of smokers to smoke ends where their behavior affects the health and well-being of others" (USDHHS 1986, p. xii). As understanding increases regarding health consequences from even brief exposures to secondhand smoke, it becomes even clearer that the health of nonsmokers overall, and particularly

the health of children, individuals with existing heart and lung problems, and other vulnerable populations, requires a higher priority and greater protection.

Together, this report and the 2004 report of the Surgeon General, *The Health Consequences of Smoking* (USDHHS 2004), document the extraordinary threat to the nation's health from active and involuntary smoking. The recent reductions in exposures of nonsmokers to secondhand smoke represent significant progress, but involuntary exposures persist in many settings and environments. More evidence is needed to understand why this progress has not been equally shared across all populations and in all parts of this nation. Some states (California, Connecticut, Delaware, Maine, Massachusetts, New York, Rhode Island, and Washington) have met the *Healthy People 2010* objectives (USDHHS 2000) that protect against involuntary exposures to secondhand smoke through recommended policies, regulations, and laws, while many other parts of this nation have not (USDHHS 2000). Evidence presented in this report suggests that these disparities in levels of protection can be reduced or eliminated. Sustained progress toward a society free of involuntary exposures to secondhand smoke should remain a national public health priority.

## References

- Armstrong BK, White E, Saracci R, editors. *Principles of Exposure Measurement in Epidemiology*. Monographs in Epidemiology and Biostatistics. Vol. 21. New York: Oxford University Press, 1992.
- Benowitz NL. Biomarkers of environmental tobacco smoke. *Environmental Health Perspectives* 1999;107(Suppl 2):349-55.
- Bero LA, Glantz SA, Rennie D. Publication bias and public health policy on environmental tobacco smoke. *Journal of the American Medical Association* 1994;272(2):133-6.
- California Environmental Protection Agency. *Health Effects of Exposure to Environmental Tobacco Smoke*. Sacramento (CA): California Environmental Protection Agency, Office of Environmental Health Hazard Assessment, Reproductive and Cancer Hazard Assessment Section and Air Toxicology and Epidemiology Section, 1997.
- California Environmental Protection Agency. *Proposed Identification of Environmental Tobacco Smoke as a Toxic Air Contaminant. Part B: Health Effects*. Sacramento (CA): California Environmental Protection Agency, Office of Environmental Health Hazard Assessment, 2005.
- Centers for Disease Control and Prevention. *Third National Report on Human Exposure to Environmental Chemicals*. Atlanta: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Environmental Health, 2005. NCEH Publication No. 05-0570.
- Copas JB, Shi JQ. Reanalysis of epidemiological evidence on lung cancer and passive smoking. *British Medical Journal* 2000;320(7232):417-8.
- Coultas DB, Peake GT, Samet JM. Questionnaire assessment of lifetime and recent exposure to environmental tobacco smoke. *American Journal of Epidemiology* 1989;130(2):338-47.
- Diethelm PA, Rielle JC, McKee M. The whole truth and nothing but the truth? The research that Phillip Morris did not want you to see, November 11, 2004; <<http://image.thelancet.com/extras/03art7306web.pdf>>; accessed: January 6, 2005.
- Emerson JA, Hovell MF, Meltzer SB, Zakarian JM, Hofstetter CR, Wahlgren DR, Leaderer BP, Meltzer EO. The accuracy of environmental tobacco smoke exposure measures among asthmatic children. *Journal of Clinical Epidemiology* 1995;48(10):1251-9.
- Fleiss JL, Gross AJ. Meta-analysis in epidemiology, with special reference to studies of the association between exposure to environmental tobacco smoke and lung cancer: a critique. *Journal of Clinical Epidemiology* 1991;44(2):127-39.
- Flue-Cured Tobacco Cooperative Stabilization Corp. v. United States Environmental Protection Agency (M.D.N.C. June 22, 1993), cited in 8.2 TPLR 3.97 (1993).
- Flue-Cured Tobacco Cooperative Stabilization Corp. v. The United States Environmental Protection Agency, No. 98-2407 (4th Cir., December 11, 2002), cited in 17.7 TPLR 2.472 (2003) (Overturning lower court's decision invalidating EPA's findings that secondhand smoke is a "known human carcinogen").
- Fontham ET, Correa P, Reynolds P, Wu-Williams A, Buffler PA, Greenberg RS, Chen VW, Alterman T, Boyd P, Austin DF, Liff J. Environmental tobacco smoke and lung cancer in nonsmoking women: a multicenter study. *Journal of the American Medical Association* 1994;271(22):1752-9.
- Garne D, Watson M, Chapman S, Byrne F. Environmental tobacco smoke research published in the journal *Indoor and Built Environment* and associations with the tobacco industry. *Lancet* 2005; 365(9461):804-9.
- Glantz SA. The ledger of tobacco control. *Journal of the American Medical Association* 1996;276(11):871-2.
- Glantz SA. Lung cancer and passive smoking: nothing new was said. *British Medical Journal* 2000;321(7270):1222-3.
- Hackshaw AK, Law MR, Wald NJ. The accumulated evidence on lung cancer and environmental tobacco smoke. *British Medical Journal* 1997;315(7114): 980-8.
- Hammond SK, Leaderer BP. A diffusion monitor to measure exposure to passive smoking. *Environmental Science & Technology* 1987;21(5):494-7.
- Hong MK, Bero LA. How the tobacco industry responded to an influential study of the health effects of secondhand smoke. *British Medical Journal* 2002;325(7377):1413-6.
- International Agency for Research on Cancer. *IARC Monographs on the Evaluation of the Carcinogenic Risk of Chemicals to Humans: Tobacco Smoking*. Vol. 38. Lyon (France): International Agency for Research on Cancer, 1986.

- International Agency for Research on Cancer. *IARC Monographs on the Evaluation of Carcinogenic Risks to Humans: Tobacco Smoke and Involuntary Smoking*. Vol. 83. Lyon (France): International Agency for Research on Cancer, 2004.
- Jaakkola MS, Jaakkola JJ. Assessment of exposure to environmental tobacco smoke. *European Respiratory Journal* 1997;10(10):2384-97.
- Jaakkola MS, Samet JM. Environmental tobacco smoke: risk assessment. *Environmental Health Perspectives* 1999;107(Suppl 6):823-904.
- Kawachi I, Colditz GA. Invited commentary: confounding, measurement error, and publication bias in studies of passive smoking. *American Journal of Epidemiology* 1996;144(10):909-15.
- Klepeis NE. An introduction to the indirect exposure assessment approach: modeling human exposure using microenvironmental measurements and the recent National Human Activity Pattern Survey. *Environmental Health Perspectives* 1999;107(Suppl 2):365-74.
- Lee PN. Difficulties in assessing the relationship between passive smoking and lung cancer. *Statistical Methods in Medical Research* 1998;7(2):137-63.
- Lee PN. Simple methods for checking for possible errors in reported odds ratios, relative risks and confidence intervals. *Statistics in Medicine* 1999;18(15):1973-81.
- Lee PN, Forey BA. Misclassification of smoking habits as determined by cotinine or by repeated self-report—summary of evidence from 42 studies. *Journal of Smoking-Related Diseases* 1995;6:109-29.
- Lee PN, Forey B, Fry JS. Revisiting the association between environmental tobacco smoke exposure and lung cancer risk. III: Adjusting for the biasing effect of misclassification of smoking habits. *Indoor and Built Environment* 2001;10(6):384-98.
- Lubin JH. Estimating lung cancer risk with exposure to environmental tobacco smoke. *Environmental Health Perspectives* 1999;107(Suppl 6):879-83.
- Matanoski G, Kanchanaraksa S, Lantry D, Chang Y. Characteristics of nonsmoking women in NHANES I and NHANES I Epidemiologic Follow-up Study with exposure to spouses who smoke. *American Journal of Epidemiology* 1995;142(2):149-57.
- Misakian AL, Bero LA. Publication bias and research on passive smoking: comparison of published and unpublished studies. *Journal of the American Medical Association* 1998;280(3):250-3.
- Morabia A, Bernstein MS, Bouchardy I, Kurtz J, Morris MA. Breast cancer and active and passive smoking: the role of the *N*-acetyltransferase 2 genotype. *American Journal of Epidemiology* 2000;152(3):226-32.
- National Health and Medical Research Council. *The Health Effects of Passive Smoking*. A scientific information paper. Canberra (Commonwealth of Australia): Canberra ACT, 1997.
- National Research Council. *Environmental Tobacco Smoke: Measuring Exposures and Assessing Health Effects*. Washington: National Academy Press, 1986.
- National Research Council. *Human Exposure Assessment for Airborne Pollutants: Advances and Opportunities*. Washington: National Academy Press, 1991.
- Ong EK, Glantz SA. Tobacco industry efforts subverting International Agency for Research on Cancer's second-hand smoke study. *Lancet* 2000;355(9211):1253-9.
- Ong EK, Glantz SA. Constructing "sound science" and "good epidemiology": tobacco, lawyers, and public relations firms. *American Journal of Public Health* 2001;91(11):1749-57.
- Pron GE, Burch JD, Howe GR, Miller AB. The reliability of passive smoking histories reported in a case-control study of lung cancer. *American Journal of Epidemiology* 1988;127(2):267-73.
- Rampton S, Stauber J. *Trust Us, We're Experts: How Industry Manipulates Science and Gambles with Your Future*. Los Angeles: J.P. Tarcher, 2000.
- Rothman KJ, Greenland S. *Modern Epidemiology*, 2nd ed. Philadelphia: Lippincott-Raven, 1998.
- Samet JM, Jaakkola JJK. The epidemiologic approach to investigating outdoor air pollution. In: Holgate ST, Samet JM, Koren HS, Maynard RL, editors. *Air Pollution and Health*. San Diego: Academic Press, 1999:431-60.
- Scientific Committee on Tobacco and Health. *Report of the Scientific Committee on Tobacco and Health*. London: The Stationery Office, 1998.
- Thornton A, Lee P, Fry J. Differences between smokers, ex-smokers, passive smokers and non-smokers. *Journal of Clinical Epidemiology* 1994;47(10):1143-62.
- Thun M, Henley J, Apicella L. Epidemiologic studies of fatal and nonfatal cardiovascular disease and ETS exposure from spousal smoking. *Environmental Health Perspectives* 1999;107(Suppl 6):841-6.
- Tweedie RL, Mengersen KL. Meta-analytic approaches to dose-response relationships, with application in studies of lung cancer and exposure to environmental tobacco smoke. *Statistics in Medicine* 1995;14(5-7):545-69.

- U.S. Department of Health and Human Services. *The Health Consequences of Smoking: Cancer. A Report of the Surgeon General*. Rockville (MD): U.S. Department of Health and Human Services, Public Health Service, Office on Smoking and Health. 1982. DHHS Publication No. (PHS) 82-50179.
- U.S. Department of Health and Human Services. *The Health Consequences of Smoking: Chronic Obstructive Lung Disease. A Report of the Surgeon General*. Rockville (MD): U.S. Department of Health and Human Services, Public Health Service, Office on Smoking and Health, 1984. DHHS Publication No. (PHS) 84-50205.
- U.S. Department of Health and Human Services. *The Health Consequences of Involuntary Smoking. A Report of the Surgeon General*. Rockville (MD): U.S. Department of Health and Human Services, Public Health Service, Centers for Disease Control, Center for Health Promotion and Education, Office on Smoking and Health, 1986. DHHS Publication No. (CDC) 87-8398.
- U.S. Department of Health and Human Services. *Preventing Tobacco Use Among Young People. A Report of the Surgeon General*. Atlanta: U.S. Department of Health and Human Services, Public Health Service, Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health, 1994.
- U.S. Department of Health and Human Services. *Tobacco Use Among U.S. Racial/Ethnic Minority Groups—African Americans, American Indians and Alaska Natives, Asian Americans and Pacific Islanders, and Hispanics. A Report of the Surgeon General*. Atlanta: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health, 1998.
- U.S. Department of Health and Human Services. *Healthy People 2010: Understanding and Improving Health*. Washington: U.S. Government Printing Office, 2000.
- U.S. Department of Health and Human Services. *Women and Smoking. A Report of the Surgeon General*. Rockville (MD): U.S. Department of Health and Human Services, Public Health Service, Office of the Surgeon General, 2001.
- U.S. Department of Health and Human Services. *The Health Consequences of Smoking: A Report of the Surgeon General*. Atlanta: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health, 2004.
- U.S. Department of Health, Education, and Welfare. *Smoking and Health: Report of the Advisory Committee to the Surgeon General of the Public Health Service*. Washington: U.S. Department of Health, Education, and Welfare, Public Health Service, Center for Disease Control, 1964. PHS Publication No. 1103.
- U.S. Department of Health, Education, and Welfare. *The Health Consequences of Smoking. A Report of the Surgeon General: 1972*. Washington: U.S. Department of Health, Education, and Welfare, Public Health Service, Health Services and Mental Health Administration, 1972. DHEW Publication No. (HSM) 72-7516.
- U.S. Department of Health, Education, and Welfare. *The Health Consequences of Smoking. A Report of the Surgeon General, 1975*. Washington: U.S. Department of Health, Education, and Welfare, Public Health Service, Center for Disease Control, 1975. DHEW Publication No. (CDC) 77-8704.
- U.S. Department of Health, Education, and Welfare. *Smoking and Health. A Report of the Surgeon General*. Washington: U.S. Department of Health, Education, and Welfare, Public Health Service, Office of the Assistant Secretary for Health, Office of Smoking and Health, 1979. DHEW Publication No. (PHS) 79-50066.
- U.S. Environmental Protection Agency. *Respiratory Health Effects of Passive Smoking: Lung Cancer and Other Disorders*. Washington: U.S. Environmental Protection Agency, Office of Research and Development, Office of Air Radiation, 1992. Report No. EPA/600/6-90/0006F.
- Vandenbroucke JP. Passive smoking and lung cancer: a publication bias? *British Medical Journal (Clinical Research Edition)* 1988;296(6619):391-2.
- Wald NJ, Nanchahal K, Thompson SG, Cuckle HS. Does breathing other people's tobacco smoke cause lung cancer? *British Medical Journal (Clinical Research Edition)* 1986;293(6556):1217-22.
- World Health Organization. *International Consultation on Environmental Tobacco Smoke (ETS) and Child Health. Consultation Report*. Geneva: World Health Organization, 1999.
- Wu AH. Exposure misclassification bias in studies of environmental tobacco smoke and lung cancer. *Environmental Health Perspectives* 1999;107(Suppl 6):873-7.
- Yach D, Bialous SA. Junking science to promote tobacco. *American Journal of Public Health* 2001;91(11):1745-8.



**Testimony: SB 25**  
**House Committee on Health & Human Services**  
**March 10, 2009**  
**Presented by: Rick Kellerman, MD**

To: House Committee on Health & Human Services  
From: Rick Kellerman, MD  
Re: SB 25

Chairwoman Landwehr and Members of the House Committee on Health & Human Services:

Good afternoon, my name is Rick Kellerman, M.D. I am here today on behalf of the Medical Society of Sedgwick County and the Kansas Academy of Family Physicians. I am a lifelong resident of Kansas and currently serve as Professor and Chair of the Department of Family and Community Medicine at the University of Kansas School of Medicine in Wichita. I am a past president of the American Academy of Family Physicians. Thank you for the opportunity to make several brief comments regarding SB 25.

It is amazing to the physician community in Kansas that the use of tobacco, a product with no health or socially redeeming value, occupies so much time and discussion among public officials. It amazes physicians that this conversation continues, despite the fact that tobacco use is the leading preventable cause of death in Kansas and exposure to any amount of secondhand smoke can cause heart disease, lung cancer and other health problems. It is amazing that while Kansas legislators debate this issue, Virginia, a state known for some 300 years as a primary grower of tobacco, has passed legislation to end smoking in public places.

I am not going to repeat the litany of medical facts about the dangers of tobacco use, or repeat the many studies showing that clean indoor air ordinances do not lead to the demise of the restaurant and bar business. Instead, I am simply going to share the opinion of the physician community represented by the KU School of Medicine-Wichita, the Medical Society of Sedgwick County and the Kansas Academy of

Family Physicians. It is time for Kansas to join the 24 other states and the District of Columbia and approve legislation restricting the use of smoking tobacco products in work sites and public places.

Your support of SB 25 will require courage and conviction, but the health of Kansans is of paramount concern. SB 25 is preventive health care at its best, and it is a win win win opportunity for the state. It will help protect the Kansans who do not smoke, which is more than 80% of our population, from the needless disease and death that result from secondhand smoke. It will also reduce disease and death among smokers. It will help prevent children from starting to smoke. With fewer smokers, Kansas taxpayers win because less money will go to smoking-related health care costs.

Kansans overwhelmingly support a statewide Clean Indoor Air Act to protect the public's health.

We ask the committee to pass the bill favorably. Demonstrate your commitment to creating healthier environments in every corner of our great state by supporting SB 25. Thank you for your consideration of this important public health issue.

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March 10, 2009

**Testimony in Support of SB 25  
Before the House Health & Human Services Committee**

**Dear Chairwoman Landwehr and Members of the Committee:**

My name is Sonja Armbruster and as the president of the Kansas Public Health Association I'm presenting written testimony in support of SB 25.

Since 1920, the Kansas Public Health Association has been working to achieve the initial charter's declared purpose of the association: to "Unite all persons and societies engaged in the promotion of public health in Kansas". This makes KPHA the oldest and *largest organization of public health professionals* and health advocates in the state. Today we represent more than **700 members** from over 50 occupations and 140 organizations in all 105 counties of the state. Our members include: researchers, academics, medical and dental care providers, health educators and advocates, administrators, teachers, private or public organizations and foundations in a unique, multidisciplinary environment of professional exchange, study, and action, in public health practice and the public health policy process.

At our annual meeting last fall, the members voted on their most important public health legislative priorities for the 2009 session, and **tobacco control, including a state wide clean indoor air law, is the number one priority.** The members of KPHA agree that

1. All Kansans deserve to breathe Smoke Free, Clean Indoor Air, no matter where in Kansas they live or work.
2. Kansans overwhelmingly support a Smoke Free, Clean Indoor Air law.
3. Smoke Free, Clean Indoor Air is good health policy and good fiscal policy.

We know you've been informed about

- polls in support of a comprehensive law,
- the strong scientific evidence of the harms of second hand smoke,
- the avoidable health care costs related to smoking,
- the fact that two public policies (clean air laws and tax increases) are the most effective policy tools to reducing the number of tobacco users, and
- that 24 states, Washington, D.C., and several countries around the world have passed smoke-free laws that cover restaurants and bars.

The challenge seems to be philosophical question about government's role in protecting health. KPHA asks that all members of the Kansas House to demonstrate their commitment to a healthier Kansas by supporting SB 25.

HEALTH AND HUMAN SERVICES  
DATE: 03/10/09  
ATTACHMENT: 4



(5)

**Date:** March 10, 2009

**To:** Representative Brenda Landwehr, Chair  
Members of House Health and Human Services Committee

**From:** Brad S. Smith, RN  
Research Nurse – Cancer Control  
Wichita Community Clinical Oncology Program  
Via Christi Health System

**Re:** SB 25

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Madame Chair and members of the Committee, I am Brad Smith, Research Nurse – cancer Control in the Wichita Community Clinical Oncology Program and I appear before you today on behalf of Via Christi Health System and in support of SB 25. Via Christi Health System's (VCHS) rich history of serving the people of Kansas and the surrounding region dates back more than 100 years to the healing ministries of our founding congregations. Today, Via Christi Health System is the largest provider of healthcare services in Kansas. We serve Kansas and northeast Oklahoma through our 10-owned or co-owned medical centers, 12 senior services communities and programs, our retail (home-based) and outpatient services, and Preferred Health Systems insurance company.

VCHS's mission is to provide the best healthcare to patients without the regard to the ability to pay. In addition to providing care to the sick and injured, we also believe it is equally important to promote good health. One of the ways in which we achieve this goal is by educating our patients and the public on the health risks associated with smoking.

In our practice, we witness first hand the variety of ways that smoking impacts people's lives. Lung cancer is one of the most obvious diseases related to smoking, and in its more aggressive form, is not noticed until it has already metastasized. Imagine, yourself at age 65 or so, looking forward to having time with your grandchildren. You are on vacation with your spouse and start having this persistent headache. You see your doctor, tests are run, and you are informed that you have a rapidly growing brain

HEALTH AND HUMAN SERVICES  
DATE: 03/10/09  
ATTACHMENT: 5



tumor. The doctor also tells you that you have a mass in your lung. Now, instead of enjoying your time with your family, your best case scenario will be months of chemotherapy and radiation. We see people facing this situation every day. Most bravely face what life brings them, but they are weakened and sickened not only by their disease, but the treatment as well. Not all of these patients with lung cancer are smokers.

I have also worked in the intensive care unit, where we care for patients who have COPD (emphysema). They come to us in acute respiratory distress and are very difficult to care for. Often these patients are in and out of the hospital frequently and are frequently ill with pneumonia.

I urge you to advance SB 25 with a favorable recommendation to the full House. SB 25 represents an important step in protecting the health of Kansas while generating savings in smoking-related illnesses and diseases. Thank you for allowing me to share my testimony with you and I would be happy to answer any questions you may have.

In FY 2007, Via Christi provided \$81.9 million in benefit to the communities we serve. This includes more than \$36 million in charity care and more than \$28 million in unpaid costs of Medicaid services provided. Our health system employs more than 9,000 and, in FY 2008, generated \$1 billion in revenue.

*Via Christi Health System is affiliated with the Marian Health System and Ascension Health.*

(6)

## JACE SMITH

---

1208 N. 132<sup>ND</sup> ST.  
KANSAS CITY, KS

Testimony presented to the House Health & Human Services Committee  
SB 25—Clean Indoor Air Act  
March 10, 2009

Good afternoon Members of the House Health & Human Services Committee, and thank you for hearing my testimony. My name is Jace Smith, and I'm speaking before you as a concerned citizen of Kansas City, KS. I would like to share with you my story, and why I want to see our state pass a strong clean indoor air law, without exemptions, for all places of employment.

While attending Emporia State University, like many students, I had to work to cover my college tuition and expenses. After applying at several places, I was able to find employment with a local bar. My schedule varied, but usually I worked 3 nights a week.

After working there for two months, I noticed a change in my health. When I would come home from working a shift, my eyes would be blood shot, and my clothes would smell like smoke. From the beginning, I knew I was working in an unhealthy environment, but really I didn't care, because I was making money, and was thankful to have a job. Then one night after work, as I was getting ready for bed, I suddenly had trouble breathing. My throat was felt tight, and I began to wheeze. I couldn't catch my breath. After a trip to the emergency room, I found out that I had suffered an asthma attack.

There is no cure for adult asthma. I take medication to control my symptoms, and try my best to avoid any possible triggers, like secondhand smoke. I'm here today to speak up for restaurant and bar workers who have to make a living in these toxic environments. No worker should have to risk their health in order to earn a paycheck.

Today, 20 million Americans are living with asthma, and are forced to avoid public places that allow smoking. Think of the increased revenue businesses would see if smoking was prohibited in all public places.

I currently make the 15-20 minute drive to Overland Park, KS, where they have implemented a strong, comprehensive smoke-free law. The County Commission in KCK failed residents like me, and passed a weak ordinance. That's why I'm here today.

As the U.S. Surgeon General concluded when issuing a groundbreaking report in June 2006, "The debate is over. The science is clear: Secondhand smoke is not a mere annoyance, but a serious health hazard that causes premature death and disease in children and nonsmoking adults."

Secondhand smoke is a health hazard, I'm proof of that. I support Senate Bill 25, and would like your support as well. Thank you for your time.



Jace Smith  
1208 N. 132<sup>nd</sup> St.  
Kansas City, KS

HEALTH AND HUMAN SERVICES  
DATE: 03/10/09  
ATTACHMENT: 6

(7)

Testimony Before the House Health and Human Services Committee  
1:30 pm, Tuesday, March 10, 2009  
Docking Office Building, 784

Testimony in Support of the SB 25  
by Karen Kelly, MD  
Deputy Director, University of Kansas Cancer Center

Madam Chairwoman and Members of the Committee:

I am Karen Kelly, the deputy director of the University of Kansas Cancer Center and a lung cancer oncologist. I would like to thank you for the opportunity to speak in support of SB 25, which would protect Kansans from the dangers of secondhand smoke.

I appear here not in my role as deputy director, but as a medical scientist with a long history of lung cancer research and as an oncologist who sees lung cancer patients on a daily basis. More importantly I am here on behalf of the 1,530 people who died from lung cancer in Kansas this past year.

Those of us who have devoted our professional lives to the defeat of disease recognize tobacco as the single most important and most controllable threat to human health in this country and the state of Kansas. The use of tobacco is addictive to smokers, and it exposes both smokers and bystanders, who share the environment with smokers, to the same deadly toxins. Extensive studies, including United States Surgeon General Carmona's 2006 report, document the contributions of tobacco products to the causation of several types of cancers, most notably lung cancer. Without tobacco use, the rates of lung cancer – the number one cancer killer, killing more people than breast, colon and prostate cancers combined – would be reduced by about 80 percent and the incidence of overall cancer would be reduced by a third. In addition to cancer, tobacco use is a major factor in chronic and acute cardiovascular disease.

Day in and day out, I see mothers, fathers, the young and the old in my clinic battling this devastating disease. I have to tell them that their disease may be treatable, but not curable. I see the devastating effects of lung cancer on patients and their families and, knowing that it is largely preventable, it is frustrating to see so many patients afflicted.

We know that by enforcing smokfree laws we will be able to save thousands of lives and prevent the type of suffering from Kansans that I see in my clinics everyday. The proposal to ban smoking in public places, including workplaces, is an important component of our effort to reduce the number of cancer deaths in Kansas.

Studies show that significant exposure to secondhand smoke occurs in many work places, and that a full ban on smoking in these settings is required to achieve a significant reduction in

exposure. By implementing a ban, we can predict that significant reductions in cancer incidence will follow as a result of reduction of exposure to secondhand smoke.

In a recent report released by the National Cancer Institute, cancer deaths dropped for the first time in 10 years; death rates for all cancers combined are decreasing for both men and women. The report noted that the states that experienced the most significant decline in cancer related deaths were states that adopted a Clean Indoor Air Act and implemented a Tobacco User Fee. This is our opportunity to join these states that are making a difference in the fight against cancer.

Respectfully submitted,

Karen L. Kelly, MD



**Testimony Concerning a Statewide Indoor Smoking Ordinance in Kansas**

Kansas House Hearing Concerning Senate Bill No. 25,  
Committee on Health and Human Services

John S. Neuberger, DrPH, MPH, MBA

Professor, Department of Preventive Medicine and Public Health,  
University of Kansas School of Medicine, Kansas City, KS 66160

March 10, 2009

Numerous health problems, including heart and lung disease, result from exposure to second-hand smoke. Smoke exposure needs to be controlled in public places and workplaces. This public health issue transcends the narrow interests of a self serving few.

To determine local government leaders' opinions on the subject I conducted an indoor smoking survey of city officials of Class I Kansas cities in 2008. The survey was distributed to Governing Board members and returned by mail. The response rate approached 90 percent for cities and 50 percent for individuals. This survey represented more than 650,000 people, the largest sample concerning this issue.

Sixty percent of respondents felt the State should mandate a comprehensive indoor smoking regulation, with local enforcement. Over 70 percent favored greater restrictions on smoking indoors. Among these, over 90 percent favored restrictions in health care facilities, motion pictures, indoor sports arenas (including bowling alleys), restaurants, and shopping malls. Between 80 and 90 percent favored restrictions in lobbies, enclosed spaces in outdoor arenas, and hotel/motel rooms. Approximately 62 percent favored restrictions in bars and casinos. Employee and public health concerns were cited by 76-79 percent of the respondents as motivators for a stricter ordinance (See separate materials dated 8/13/08).

I strongly support Senate Bill 25 but it should be strengthened by eliminating exemptions for 20% of hotel/motel rooms and certain private clubs, particularly if minors are allowed to enter. A strong state law will minimize health and environmental disparities for minority and other workers.

Some individuals have testified in many Kansas cities in opposition to such an ordinance on the grounds that it violates the rights of business owners. However, these rights do not include the right to create or trigger health problems in their employees and customers.

Bar and restaurant owners have testified that such an ordinance could cause economic harm to their businesses. However, both the New York State Health Department and the Centers for Disease Control have found that there are no negative economic effects on their industry from indoor smoking ordinances.

Opponents of local clean indoor air legislation have frequently stated that they would prefer a statewide indoor smoking ordinance to "level the playing field". For the health of all Kansans I recommend the strongest possible statewide ordinance.

(9)

## Testimony Concerning a Statewide Indoor Smoking Ordinance in Kansas

Kansas House Hearing Concerning Senate Bill No. 25,  
Committee on Health and Human Services

John S. Neuberger, DrPH, MPH, MBA

Professor, Department of Preventive Medicine and Public Health,  
University of Kansas School of Medicine, Kansas City, KS 66160

March 10, 2009

While I support Senate Bill 25, it could be strengthened considerably by eliminating the exemptions for 20% of hotel/motel rooms and for private clubs, particularly if minors are allowed to enter.

I conducted an indoor smoking survey of city officials of Class I Kansas cities in 2008. The survey was to be distributed to all Governing Board members and returned by mail. The response rate approached 90 percent for cities and 50 percent for individuals. This survey represented more than 650,000 people, the largest state sample concerning this issue.

Sixty percent of respondents felt that the State should mandate a comprehensive indoor smoking regulation, with local enforcement. Over 70 percent favored greater restrictions on smoking indoors. Among these, over 90 percent favored restrictions in health care facilities, motion pictures, indoor sports arenas (including bowling alleys), restaurants, and shopping malls. Between 80 and 90 percent favored restrictions in lobbies, enclosed spaces in outdoor arenas, and hotel/motel rooms. Approximately 62 percent favored restrictions in bars and casinos. Employee and public health concerns were cited by 76-79 percent of the respondents as motivators for a stricter ordinance (See separate materials dated 8/13/08).

There are numerous health problems, including heart and lung disease, resulting from exposure to second-hand smoke. The rights of business owners do not include creating or exacerbating such problems in their employees and customers. A strong state law will minimize health and environmental disparities.

Both the New York State Health Department and the Centers for Disease Control and Prevention have found that there is no negative economic effect on the bar and restaurant industry from indoor smoking ordinances.

Bar and restaurant owners have testified previously in many Kansas cities that they would prefer a statewide indoor smoking ordinance to "level the playing field". Give them their statewide ordinance.

## Indoor Smoking Ordinances in Workplaces and Public Places in Kansas

John S. Neuberger, DrPH, MPH, MBA, Ken Davis, PT, MPH, Nancy Dunton, PhD,  
Niaman Nazir, MBBS, MPH, University of Kansas Medical Center

August 13, 2008

### ABSTRACT

An indoor smoking survey of city officials of Class I Kansas cities was conducted in the spring of 2008. The survey was mailed to city clerks with a request for distribution to all Governing Board (GB) members (council plus mayor). A request was made to return the survey along with any indoor smoking ordinances. Information was collected on the respondent's age, gender, smoking status, attitudes towards indoor smoke exposure in workplaces and public places, the need for statewide legislation, what venues should be covered, and the important factors driving the need to legislate. Simple unweighted percentages were used in calculating responses (total and by gender and smoking status).

The response rate approached 90 percent for cities and exceeded 50 percent for GB members. The overall population represented exceeded 650,000. Two-thirds of the respondents were male and 3.7 percent were current smokers.

Sixty percent of responding Class I city GB members agreed that the State should mandate a comprehensive indoor smoking regulation, with local enforcement. Many agreed that both the city and state should be involved in restricting smoking. GB members who had never smoked tended to favor a more restrictive approach than smokers. Over 70 percent of the respondents favored or strongly favored greater restrictions on smoking indoors. Among these, over 90 percent favored restrictions in health care facilities, motion pictures, indoor sports arenas (including bowling alleys), restaurants, and shopping malls. Between 80 and 90 percent favored restrictions in lobbies, enclosed spaces in outdoor arenas, and hotel/motel rooms. Approximately 62 percent favored restrictions in bars and casinos. Employee and public health concerns were cited by 76-79 percent as motivators for a stricter ordinance.

This study is of representatives of a large population of Kansans and allowed all GB members a chance to be heard. Response rates were excellent for cities and fairly good for individual GB members. Relatively few current smokers were included, compared to state data for the general population. Representatives of rural areas and smaller cities were not included. Representatives of some cities with ordinances did not participate.

The majority of surveyed GB members who responded indicated majority support for dual (local, State) legislation and viewed indoor smoking as an important health issue. Compared to an earlier population survey, GB members were not as enthusiastic about such ordinances as the general population. Of those who favored legislation, the majority believed it should apply to all venues. Cigarette smoking seemed to be an important predictor of responses. Cigarette smokers may have been under-represented in the survey.

# Indoor Smoking Ordinances in Workplaces and Public Places in Kansas

John S. Neuberger, DrPH, MPH, MBA  
Ken Davis, PT, MPH  
Nancy Dunton, PhD  
Niaman Nazir, MBBS, MPH

University of Kansas Medical Center

August 13, 2008



# Introduction

Sunflower Foundation Sponsored Survey

February 2007

Random Digit Dial Telephone Survey

Sample of 500 (error  $\pm 4.4\%$ )

## Introduction (Con't.)

### Favor a Smoking Ban for Clean Indoor Air

Current Smokers (20%)	31%
Former Smokers (34%)	76%
Never Smokers (48%)	84%

## Introduction (Con't.)

Favor a Clean Indoor Air Law in your community or State that would include all indoor workplaces and public places, including restaurants and bars?

	Community	State
Favor	73	71
Strongly Favor	59	59



## Introduction (Con't.)

Is Secondhand Smoke a Health Hazard?

Yes	83%
Yes, a Serious Health Hazard	59%



# Methods

Survey Mailed to City Clerks (LKM)  
March 2008

Fifty Seven Class I Cities in Kansas  
( $>5,000$  in population)

117

## Methods (Con't.)

Distributed to Governing Board (GB)  
Members

Stamped, self-addressed return  
envelopes provided

## Methods (Con't.)

Age

Gender

Smoking status



## Methods (Con't.)

Attitudes towards indoor smoke exposure  
in work places and public places

Need for statewide legislation

What venues should be covered

Importance of legislation



## Methods (Con't.)

No identification of individual respondents

Copy of Ordinance

Phone calls to all non-responding cities

Unweighted Percentages

## Methods (Con't.)

Population represented:

1,821,470

[67.9% of 2,681,983]

## Results

Response rate: 51 out of 57 cities = 89.5%

190 out of 377 GB members = 50.4%



11-13

## Results (Con't.)

Cities not responding:

Atchison, Dodge City, Kansas City (KS),  
Lawrence\*, Olathe\*, and Salina\*

Population not represented: 429,463

Net: 1,392,007

\* Cities with smoking ordinances



## Results (Con't.)

Reasons for not responding:

No idea

Did not want to participate

Surveyed out

Mayor did not want survey distributed

## Results (Con't.)

### Respondents: Age (Q #11)

19-39	21	11.1 %
40-59	91	47.9 %
60-79	62	32.6 %
Not stated	16	8.4 %

## Results (Con't.)

### Respondents: Gender (Q #12)

Male	127	66.8 %
Female	50	26.3 %
Not stated	13	6.8 %



## Results (Con't.)

Respondents: Smoking status (Q #10)

Current smoker	7	3.7 %
Former smoker	66	34.7 %
Never smoker	104	54.7 %
Not stated	13	6.8 %



## Results (Con't.)

Respondents: Currently Live with a Smoker  
(Q #10)

Yes	11	5.8 %
No	152	80.0 %
Not stated	27	14.2 %

## Results (Con't.)

Has Your City Government Passed  
Restrictions on Smoking in Public Places and  
Workplaces Beyond State Statutes?  
(Q #4)

Yes	59	31.1 %
No	121	63.7 %
Not stated	10	5.3 %



## Results (Con't.)

### Positive Responses on Previous Question

Yes from a Respondent	59	31.1 % (Responses)
Number of Cities	23	45.1 % (of 51 cities)
Ordinances Provided	19	82.6 % (of 23 cities)

## Results (Con't.)

Should the State Mandate a Comprehensive Indoor Smoking Regulation Enforced Locally? (Q #5)

Yes	114	60.0 %
No	67	35.3 %
Not stated	9	4.7 %



## Results (Con't.)

Should the State Mandate a Comprehensive Indoor Smoking Regulation Enforced Locally? By Gender. (Q #5)

	Total	Male	Female	Not Stated
Yes %	60.0	63.0	58.0	38.5
No %	35.3	33.9	36.0	46.2
Not Stated %	4.7	3.2	6.0	15.4

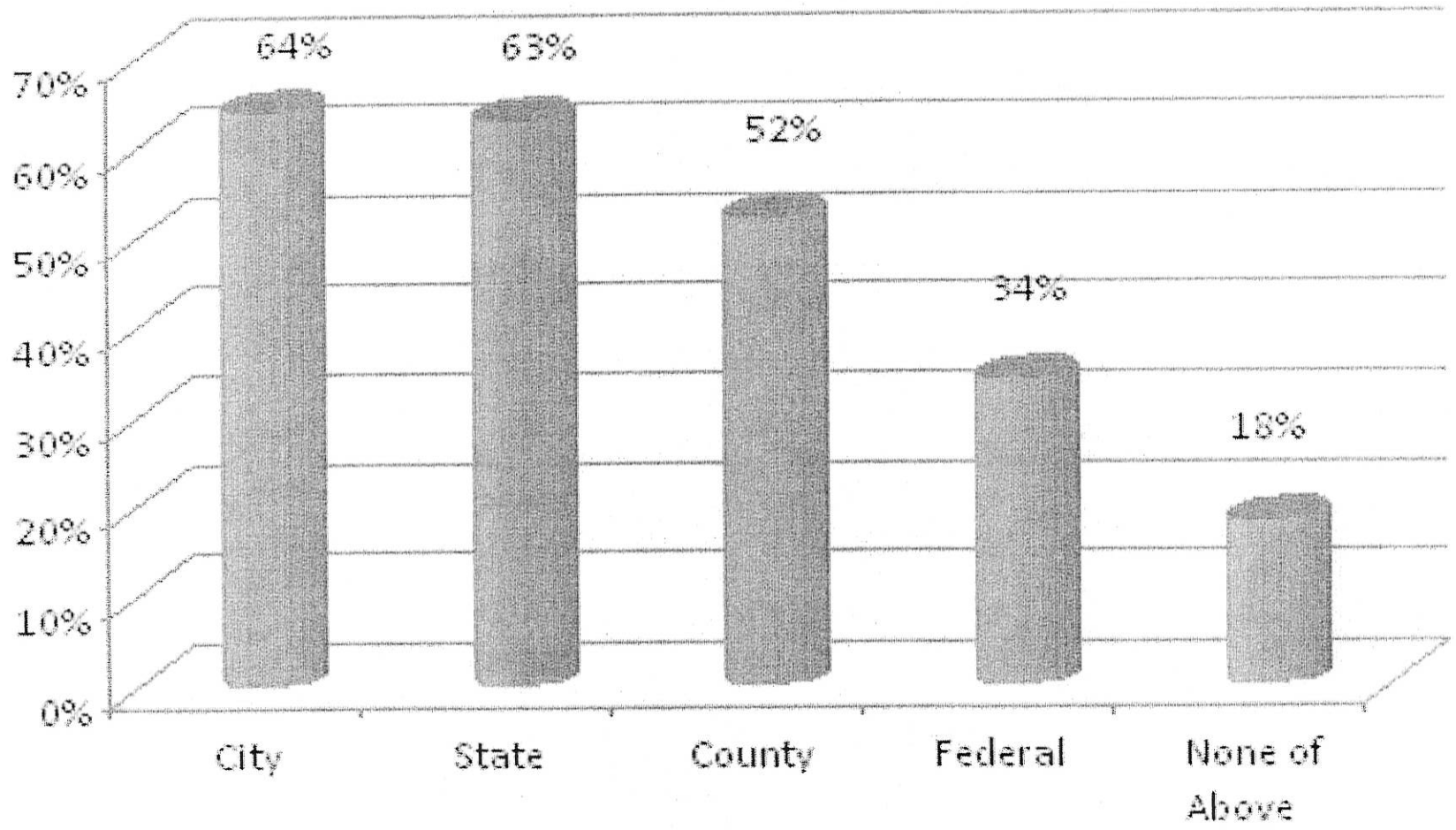
## Results (Con't.)

Should the State Mandate a Comprehensive Indoor Smoking Regulation Enforced Locally? By Smoking Status. (Q #5)

	Total	Current	Former	Never	Not Stated
Yes %	60.0	28.6	59.1	67.3	23.1
No %	35.3	71.4	37.9	28.9	53.9
Not Stated %	4.7	0.0	3.0	3.9	23.1

# (Q #6)

## Which Levels of Government Should be Involved in Restricting Smoking?





March 10, 2009  
Testimony in Support of SB 25 before the  
House Committee on Health and Human Services

Chairwoman Landwehr and Members of the Committee:

I am Dr. Trent W. Davis, a citizen of Salina, Kansas. I am a Neurologist with over thirty years experience, and am active in the Saline County Tobacco Prevention Coalition. Over my entire career I have treated strokes and other tobacco related illnesses. While treating strokes is rewarding, the real fulfillment is in preventing a stroke. A clean indoor law will ensure that social and financial savings occur.

So far, this issue has been left up to individual communities in Kansas. I have been involved in two tremendous city-wide struggles on this public health issue. This city by city process has come at a high cost, however. A community health issue in Salina and in other Kansas cities has been hijacked to include all sorts of political agendas and "dirty tricks", often leaving neighbors mad at each other, and setting up smokers versus non-smokers at the local level. Petitions and counter petitions, elections and special elections come at great cost. This process deteriorates into one in which the deep pockets of the opposition wreaks havoc with the will of the majority. The disagreement is rarely over whether smoking is dangerous for our health; instead issues of "business rights" and "economic detriment for business" have dominated the discussion by an industry making money by recruiting and slowly killing our youth.

Look at the remarkable reduction in heart attacks in Pueblo, CO after its Clean Indoor Air ordinance went into effect. Imagine the larger cost savings from reduced bronchitis, pneumonia, sinusitis, sore throat, SIDS, numerous cancer types, including lung cancer, ulcers, and employee absenteeism. We ALL end up paying the cost; not least of all through taxpayers' money.

To keep Kansas as a smoking-friendly state sends a message that we value a perceived loss of income as more important than the real cost of health. You have the opportunity to be at the forefront of improving health in Kansas by adopting the Kansas Clean Indoor Air Act. I urge your consideration and support of this critical policy as a win for Kansans' health and finances.

Trent Davis, M.D.  
t2pacdavis@cox.net  
cell 785 493-1038  
home 785 823-0287



13

March 10, 2009

**Testimony before the House Health and Human Services Committee  
Representative Brenda Landwehr, committee chair, and members of the committee  
RE: In Support of Senate Bill 25**

I have read recently that proponents of a statewide "ban" on smoking in indoor public places will emphasize the financial benefits to Kansas of such a state law. Secondhand smoke does indeed cost the state significantly.

Numerous scientific studies have not supported the contention that indoor smoking restrictions are bad for restaurant business and why would they since over 80% of Kansans do not smoke. Why would catering to 20% of the population be a good idea?

But secondhand smoke is really a health matter. A study reported in newspapers within the last month has shown that life expectancy has increased in the studied areas where outdoor air quality has been improved. Why wouldn't cleaning up indoor air be beneficial as well?

On November 9 last year my 40-year-old daughter died of breast cancer. As a teenager she began working in fast food restaurants where smoking was permitted. She was still working in smoky restaurants when she was diagnosed at age 28. Some studies have shown a statistical link between breast cancer in young women and exposure to tobacco smoke.

I can't say with certainty that secondhand smoke caused Amy's death, but nobody can say that it didn't. Our youngest daughter is now 13 and I can guarantee that she will never work where smoking is permitted as long as she is under parental control even if it means she can't afford to go to college. Ask yourself if you would let your child or grandchild work where tobacco smoke is present. What is their life worth?

No business has the "right" to permit a dangerous substance to be unnecessarily present where employees or patrons are present. Any employer who does so is playing with the lives of these people. I support the free enterprise system (my father owned his own business as did my late daughter) and am opposed to unnecessary regulations that can burden businesses. However, we do have many necessary regulations that protect the health and welfare of our citizens. That is the role of government.

2009 is the year for Kansas to act and join other states like nearby Colorado, Nebraska and Iowa which have passed statewide laws to protect their citizens and visitors from the dangers of environment tobacco smoke. According to the U.S. Surgeon General's Report there is no safe level of exposure to tobacco smoke.

Dave Pomeroy  
2321 SE Libra Ct.  
Topeka, KS 66605-3505  
davepomeroy@sbcglobal.net

HEALTH AND HUMAN SERVICES  
DATE: 03/10/09  
ATTACHMENT: 13



3/10/09

Honorable Chairman Landwehr and Members of the Health and Human Services Committee,

My name is Louie Riederer and I live in Lenexa, KS

I own five Johnny's Taverns which are located in Johnson County and I employ 150 people.

Thank you for allowing me the opportunity to address an issue that is important to me and to my business.

I've come full circle on smoking bans. I was initially against them but now I fully support them. Of my customers, 99% have commented on how much they like being in a non-smoking environment.

My patrons are happier and my employees are healthier despite my fears that smoking restrictions would hurt my business.

Smoking restrictions in Johnson County went into effect a year ago and while business initially went down, it has come back.

The patchwork of local ordinances now in place makes things more confusing for customers and puts owners at a disadvantage. You can go from town to town and you don't know where you can smoke and where you can't. We need everybody to play by the same rules, whether you are a bar, restaurant or private club.

I urge you to pass a statewide bill that will protect all hospitality workers and patrons.

Louie Riederer  
9503 Falcon Ridge Dr.  
Lenexa, KS 66220-3640  
913-226-6376

Johnny's Tavern's  
**Johnny's Lawrence**

**Johnny's Overland Park**

HEALTH AND HUMAN SERVICES  
DATE: 03/10/09  
ATTACHMENT: 14

401 N. 2nd Street  
Lawrence, Kansas 66044  
785-842-0377

[lawrence@johnnystavern.com](mailto:lawrence@johnnystavern.com)

**Johnny's Shawnee**

13410 W. 62nd Terrace  
Shawnee, Kansas 66216  
913-962-5777

[shawnee@johnnystavern.com](mailto:shawnee@johnnystavern.com)

**Johnny's Prairie Village**

8262 Mission Road  
Prairie Village, Kansas 66208  
913-901-0322

[prairievillage@johnnystavern.com](mailto:prairievillage@johnnystavern.com)

6765 W. 119th Street  
Overland Park, Kansas 66209  
913-451-4542

[overlandpark@johnnystavern.com](mailto:overlandpark@johnnystavern.com)

**Johnny's Blue Valley**

11316 W. 135th Street  
Overland Park, Kansas 66211  
913-851-5165

[bluevalley@johnnystavern.com](mailto:bluevalley@johnnystavern.com)

**Johnny's Olathe**

10384 S. Ridgeview Road  
Olathe, Kansas 66219  
913-378-0744

[olathe@johnnystavern.com](mailto:olathe@johnnystavern.com)



**BlueCross  
BlueShield  
of Kansas**

1133 SW Topeka Boulevard  
Topeka, Kansas 66629-0001

Web site: [www.bcbsks.com](http://www.bcbsks.com)

In Topeka – (785) 291-7000  
In Kansas – (800) 432-0216

16

Statement of Graham Bailey  
Vice-President, Corporate Communications & Public Relations  
Blue Cross and Blue Shield of Kansas, Inc.  
House Health and Human Services Committee  
March 10, 2009

Dear Madam Chairwoman and Members:

Thank you for allowing me time today to provide you educational information regarding the benefits of clean air acts and to show support for the efforts of Tobacco Free Kansas with regards to enacting a statewide clean air act.

Health insurance premiums increase because the total number of services received and the cost of those services are growing at a rapid rate. The significant cost impact of tobacco-related illnesses makes access to affordable health insurance more difficult for individuals, small businesses and large employers. In addition, we all pay taxes which support insurance programs the state funds such as Medicaid and the State of Kansas employee program. I don't have to tell you that providing health care in Kansas comes with a huge price tag.

If we are truly going to be serious about lowering the cost of health care in Kansas it is essential that we find ways to make people healthier and lower the incidence of chronic diseases. We must shift our focus to making Kansas a healthier place to live and work.

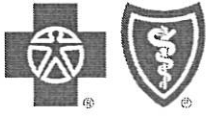
The health insurance premium formula is pretty simple:

$$\text{Number of services} \times \text{the cost of those services} + \text{administrative costs} = \text{premium}$$

Collectively, we can have the greatest impact on the cost of health care by decreasing utilization. The best way to do that is to live healthier lives and make healthier choices.

Allow me to share with you some interesting statistics. In a recent 12-month period, the average cost that Blue Cross and Blue Shield of Kansas paid for a member who suffered a heart attack was \$34,488. During that 12-month period we paid out more than \$70 million because 2,045 of our members experienced some level of heart attack.





**BlueCross  
BlueShield  
of Kansas**

1133 SW Topeka Boulevard  
Topeka, Kansas 66629-0001

Web site: [www.bcbsks.com](http://www.bcbsks.com)

In Topeka – (785) 291-7000  
In Kansas – (800) 432-0216

Earlier this month, government researchers announce the results of a three-year study which showed a dramatic drop in heart attack hospitalizations three years after Pueblo, Colorado, adopted a clean air policy. The smoking ban is credited with reducing heart attack admissions 41 percent.

Applying that percentage to the number of our members who had heart attacks during the 12-month period I previously mentioned means that 838 fewer people would have had heart attacks, saving \$28.9 million in claims expense.

Clearly, clean air acts lower utilization, therefore making health care more affordable. How much money could the state save if 41 percent fewer people covered by Medicaid or those in the State of Kansas employee group had heart attacks? I think that is an important question for you to ask yourselves.

Studies indicate that 10-12 percent of today's health care costs are attributable to smoking-related conditions and diseases. The Society of Actuaries has determined that second-hand smoke costs the United States economy \$10 billion a year -- \$5 billion in exposure to illness and \$4.6 billion in lost wages. The Centers for Disease Control and Prevention estimates that smoking costs the U.S. economy \$92 billion a year in lost productivity.

I don't believe anyone can come before you and credibly argue that smoking is good for you or for those who breathe second-hand smoke. However, I do think a credible argument can be made that clean air acts provide tremendous financial benefits by lowering utilization and increasing productivity. And, this is really good news, enacting a clean air act costs little or no money to the state. It is one of the most cost-efficient and simplest ways that you can have an immediate and substantial impact on the health of all Kansans.

Thank you for your time. I would be happy to answer any questions you might have at this time or I can be available after the hearing.

March 10, 2009

*Testimony in support of Senate Bill 25  
before the House Committee on Health and Human Services*

**Dear Chairwoman Landwehr and Members of the Committee**

I give you this statement as Mayor Pro Tem of Manhattan, a business manager, and a citizen of Kansas. I strongly support a statewide ban on smoking inside public places.

Earlier this month, Manhattan implemented a petition ordinance banning smoking inside public places, places of employment, as well as in other areas. The petition process itself was difficult for both our citizens and elected officials - in many ways pitting the community against itself. The implementation process resulted in an ordinance that met neither the desires of the drafters nor the expectations of voters. And further, it is my understanding that today some of our local establishments are losing business to other communities.

This would have not been the case had the Kansas Legislature implemented a simple, straightforward law that applied across our State. A law that would "level the playing field" for all businesses, avoid the costly local ordinance approach, benefit - not cost - small businesses, and prevent illnesses associated with second hand smoke.

If put to a statewide ballot, I am confident citizens of our State would favor such a law and do so by a wide margin. I encourage you as our representatives to do the right thing and move forward with this legislation.

Respectfully,

*Bob Strawn*

RJS/s

(17)

# Emporians for Drug Awareness, Inc.

*Working for a Safer Community*

*PO Box 2015  
Emporia KS 66801*

*620.341.2450 voice  
620.341.2456 fax*

Written Testimony before the House Health and Human Services Committee  
In Support of SB 25 Kansas Clean Indoor Air Act

March 10, 2009

Dear Madam Chair and Members of the Committee:

Our state is currently dotted with hybrid ordinances that each ban smoking in public places with some noticeable differences:

- The distance one can smoke from the building varies, depending on which community's ordinance is being reviewed;
- The type of business where the smoking is banned may be different – some include restaurants but exclude bars while others include *all* workplaces; some include all motel rooms, some a percentage; some exclude fraternal organizations;
- One can smoke in an outside smoking area according to some ordinances while some dictate that smoking patios are not allowed;
- Some base the ban on the time of day the smoking is to occur or whether or not anyone under the age of 18 is allowed into the establishment

The one common feature of all of these grassroots ordinances is the use of legislation to protect public health by reducing exposure to secondhand smoke in public places. Interestingly enough, local governments bemoan the fact that the state has not adopted legislation while those at the state level indicate that they feel action should come from the local level. In the meantime, the health of Kansans continues to be put at risk.

While our state is struggling to cover ever-increasing costs, it makes sense that methods be considered to eliminate the incidence of preventable diseases as a way to decrease the burden to our healthcare systems. According to the U.S. Surgeon General's 2006 report, there is no safe level of exposure to secondhand smoke and only smoke-free laws provide effective protection from secondhand smoke. Diseases and deaths caused by such exposure are preventable; studies done in communities that have adopted ordinances eliminating smoking in public places demonstrate marked reduction in heart attacks and other health problems associated with smoking and secondhand smoke.

The evidence is indisputable. A vote to adopt a comprehensive state-wide law for clean air is a prudent method of saving the lives of Kansans.... all day, every day, no matter their age or where they work.

Respectfully,

Teresa Walters, C.P.S.  
Executive Director

HEALTH AND HUMAN SERVICES  
DATE: 03/10/09  
ATTACHMENT: 17

March 10, 2009

TO: House Committee on Health and Human Services

FROM: Cathy Porter, Volunteer for American Heart Association

RE: SB 25—Clean Indoor Air

Madam Chairwoman and members of the committee:

Thank you for allowing me to submit written testimony on this most important issue of a law for clean indoor air. My name is Cathy Porter and I am a volunteer for the American Heart Association. I am a heart survivor. My story began almost 11 years ago when I suffered a massive heart attack the day before my 45th birthday. My only risk factor was smoking; women who smoke will have a heart attack 20 years early than those who don't smoke. Smoking weakens the lining of your arteries and causes the soft plaque to become unstable, many times resulting in a heart attack. That is how it happened to me. Over the next five years my heart began to change shape and I had to undergo open heart surgery, where an aneurysm was removed from the left ventricle. Because of the damage caused by my heart attack, the pumping function of my heart is only half of what it should be and I suffer from an electrical condition, known as ventricular tachycardia, which can cause sudden cardiac arrest.

We always hear of these stories but never think it will happen to me. I never thought it would happen to me, a 45 year old woman, but it did. I stand before you today not only to tell you about my story, but the health benefits of reduced exposure to secondhand smoke in all public areas: to the vulnerable populations, the scientific proof, the studies exist indicating before and after proof of clean indoor air health benefits in countries and communities, and to ask your support for SB 25.

Cigarette smoke not only harms the smokers, but **vulnerable populations** that are subjected to secondhand smoke:

- ♥ *especially* **employees in establishments that allow smoking**, (do you know their risk of lung cancer triples; and increases your risk of heart attack up to 50%; and for women the risk of heart attack is 91% higher for women regularly exposed to secondhand smoke.....AND,
- ♥ *especially* **children** who each year develop asthma, lower respiratory tract infections and other breathing difficulties, and with low birthweight in babies, due to secondhand smoke contributing to infant mortality and health complications into adulthood, i.e., leukemia, thyroid damage for both the mother's and the baby's thyroid function, .....AND
- ♥ *especially* **minorities** who are less likely to be covered by smoke-free policies due in part because they comprise a larger percentage of blue-collar and service industry jobs....AND
- ♥ *especially* **youth and young adults** who work in an environment where only 28% have the benefits of a smoke-free workplace.

The American Heart Association considers this issue one of public health, and find it inexcusable that workers

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HEALTH AND HUMAN SERVICES  
DATE: 03/10/09  
ATTACHMENT: 18



in restaurants, bars and other facilities are forced to inhale secondhand smoke in order to earn a living. It is clear there are significant dangers associated with exposure to secondhand smoke. We have been given the second study by the Surgeon General again affirming that scientific conclusion. There is no debate. **There are no safe levels of second hand smoke.** Even the most expensive ventilation systems only remove the odor, and cannot eliminate the carcinogens in secondhand smoke that still lingering in the air.

At least six published studies exist indicating before and after proof of clean indoor air health benefits in countries and communities.

- **Pueblo, CO**— A smoking ban caused heart attacks to drop by more than 40 percent in one U.S. city and the decrease lasted three years. Pueblo, Colorado, passed a municipal law making workplaces and public places smoke-free in 2003 and U.S. Centers for Disease Control and Prevention officials tracked hospitalizations for heart attacks afterward. They found there were 399 hospital admissions for heart attacks in Pueblo in the 18 months before the ban and 237 heart attack hospitalizations in the next year and a half -- a **decline of 41 percent**. The effect lasted three years, the team reported in the CDC's weekly report on death and disease.
- **Helena, MT**—The Pueblo results mirror and expand upon those of a shorter study involving a non-smoking ordinance in the smaller community of Helena, Montana in 2003. There, **heart attacks fell 40 percent** in the six months the ordinance was in effect, but returned to previous levels after a legal challenge suspended the ordinance.
- **England**—06/14/2008. The number of heart attacks has fallen dramatically since the ban on smoking in public places was introduced last year, latest figures reveal. More than half of hospital trusts in England are treating fewer heart attacks since the ban came on July 1 last year. Nearly six in ten NHS trusts are reporting a fall in the number of heart attack patients being admitted to emergency wards. There were 1,384 fewer heart attacks across the county in the nine months after the legislation was introduced compared with the same period a year earlier. That translates to a three percent fall across the country since the ban. Some hospitals have seen the **number of cases fall by 41 per cent since July 2007**.
- **Scotland—June 23, 2008**. Dr David Batty, of the Medical Research Council Social and Public Health Sciences Unit, based at the University of Glasgow, said: "What this study shows is that smoking is linked to more kinds of cancer than previously thought. It's important to remember that cancer is not a single disease and that the various kinds of cancers are different illnesses so you couldn't necessarily assume that smoking was linked to them in the same way. What's unclear is how exactly smoking causes these cancers." Health Minister Shona Robison said: "This study appears to demonstrate that smoking is even more carcinogenic than was realized. It also underlines the importance of Scotland's smoking ban in public places, which is helping to safeguard the health of thousands of people working in previously smoky environments." Sheila Duffy, chief executive of Action on Smoking and Health Scotland, said: "This large-scale study adds to the weight of existing research confirming the harmfulness of smoking. It's vital that smokers receive support and encouragement to quit and as a nation we take steps to ensure future generations avoid getting hooked on this lethal and highly addictive substance." Ed Yong, health information manager at Cancer Research UK, said: "The dangers of cigarette smoke go far beyond its well-known link to lung cancer. It's interesting to see that even after 50 years of research, studies are still revealing new dangers."

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- **Italy**—February 11, 2008. Italy's 2005 smoking ban has led to a sharp fall in heart attacks, researchers reported on Monday in a finding they said shows that such laws really do improve public health. Following the ban the number of heart attacks in men and women aged 35-64 -- people most likely to be exposed to smoke in cafes, bars and restaurants -- **fell 11 percent**, the researchers said. The findings showed the health benefits of European smoking bans in public places, said Francesco Forastiere, an epidemiologist at the Rome Health Authority who led the study. "Most of this change is due to the decreased impact of passive smoke," he said in a telephone interview. "This is ... important because it shows the impact of a health intervention that can be achieved in other countries." Italy, Britain, Ireland and a number of other European countries have outlawed smoking in public places, and many health experts are urging the European Union to adopt an even wider ban. The ban in Italy, where the researchers said about 30 percent of men and 20 percent of women smoke, prohibited smoking cigarettes in all indoor public places such as offices, retail shops, restaurants, pubs and discos.
- **France**—February 24, 2008. The incidence of smoking-related diseases has sharply decreased after France enacted tough anti-smoking laws, the Health Ministry said in a report released Saturday. According to the report, the incidence of **myocardial infarction and cerebrovascular diseases dropped by 15 percent in recent two months**. It will be further proved in the next two months that anti-smoking laws will bring significant and instant benefits to the health of the French people, said the report. French has banned smoking in companies, government offices and shopping centers since Feb.1, 2007. From the beginning of this year, smoking are banned in all public places across France, including bars, cafes, restaurants and discotheques.
- **Kansas**—The Kansas Department of Health and environment took Pueblo's result to develop a scenario that could occur in Kansas based on our health statistics. KDHE reports that if Kansas experienced similar results to Pueblo, there would be 2,160 fewer heart attacks and \$21 million less spend on the related health care costs for public and private hospitals annually.

The American Heart Association continues to support smoke-free policies that provide for 100% smoke free public places, including restaurants and bars... free of exemptions for separately ventilated rooms, size or hours of operation exemptions, exemptions for bars or private clubs or recreational establishments, and opt-out provisions. We want to make Kansas to make a healthier place for all its citizens.

Elected leaders must continue to move toward a 100 percent smoke-free nation and help reduce death and disability from cardiovascular diseases and other diseases. When we come together in public, all things being equal, the least that should be expected of all of us is to do no harm to one another. I urge you to pass SB 25 favorably for passage. Thank you.


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100

# AMERICAN HEART ASSOCIATION

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**Not me!**



Heart disease kills one in three American women — but you have the power to prevent it.

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Take the  
**Go Red Heart Checkup**  
at [GoRedForWomen.org](http://GoRedForWomen.org).

- Answer a few questions.
- Learn your risk.
- Get a personalized action plan to reduce your risk.
- Talk with your healthcare provider about your findings.

**Join the Go Red Movement!**

Go Red For Women is the American Heart Association's national movement to help women reduce their risk of heart disease.



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March 10, 2009

Madam Chairwoman and Members of the House Committee on Health & Human Services:

I thank you for this opportunity to write to you about an issue I feel very strongly about...a clean indoor air law. I appreciate being able to state my opinion.

The attachment tells my story and gives you a great deal of information about women's heart health in Kansas. Did you know that the risk of heart attack is 91% higher for women regularly exposed to secondhand smoke?

Since I have made a commitment to myself to be a strong and healthy woman, I would always make a life choice that supported continued good health for my life and for my family's life. There is nothing about a smoking environment or a second and even third hand smoking environment that promotes any component of a good health.

As I travel to other states (many of them having clean indoor air laws), I find coming home to Kansas not always a good thing because of the air we are forced to breathe as we dine out in restaurants and participate in activities in the public arena. I do not appreciate going to any establishment as a customer and hard working tax payer and have to choose whether I can eat at that particular restaurant or not because they allow others to smoke.

The government would never let restaurants hang asbestos from the ceilings or be rat infected and still operate their business. However, subjecting someone to secondhand smoke is just as bad and people don't seem to realize that, or worse just ignoring the fact. Just separating smokers from non-smokers in different rooms does not address the issue. Air is still air and the smoke still spreads to innocent bystanders.

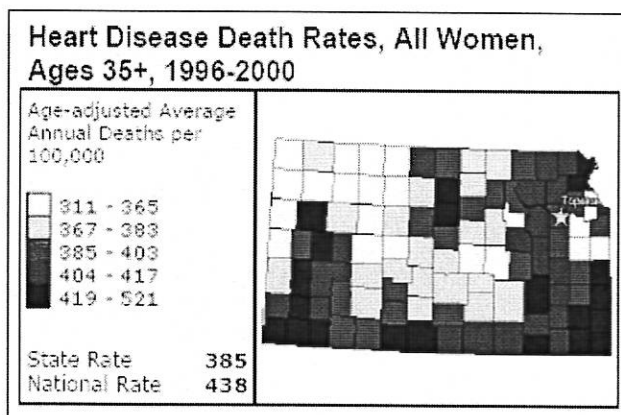
Enacting a statewide clean indoor air law is one of the most cost effective ways to improve health. This is a preventative policy that protects non-smokers, provides an environment for smokers to quit and encourages children to never start smoking. With fewer smokers, the Kansas taxpayers win because less money will go to smoking-related health care costs.

I feel our state has a responsibility to provide any and all residents with health conscious environments that promote good health for its citizens. I support SB 25, I hope you will pass this bill. Thank you.

- Gail Dicus, Kansas Resident and National Face of American Heart Association's Go Red For Women Movement.

## Women and Cardiovascular Disease State Facts: Kansas

- Heart disease, stroke, and other cardiovascular diseases are the No. 1 killer of women in Kansas.
- Heart disease and stroke account for 31% of all female deaths in Kansas.
- On average, nearly 11 females die from heart disease and stroke in Kansas each day.



- Heart disease alone is the leading cause of death in Kansas, accounting for 3,005 female deaths in 2005.
- Stroke is the No. 3 cause of female death in Kansas, accounting for 984 female deaths in 2005.
- Nearly 57% of women in Kansas are overweight and obese.\*
- In Kansas, 17.1% of women smoke cigarettes.

Source: Centers for Disease Control and Prevention. Mortality data based on WISQARS Leading Cause of Death Reports, 2005; state maps from the Division of Heart Disease and Stroke Prevention; risk factor data from the BRFSS, 2007.

\* Overweight is defined as having a body mass index (BMI) of 25.0-29.9 and obese is defined as having a BMI of 30.0 or greater.

### Gail Dicus Kansas Survivor

Seven years ago, Gail Dicus of Leawood, Kan., was traveling life's highway at a nice speed, obeying the "speed limit and rules." Then a major detour changed her course. She knew something was just not right when she struggled to recover from lingering bronchitis, was bone tired and short of breath. After several visits with doctors, she was diagnosed with cardiomyopathy, a disease of the heart muscle that caused enlargement of the heart.

For the next four years, Gail worked with cardiologists to sustain her life. She entered a new world of medicines and their side effects, tests and procedures, all while trying to maintain her business and family life. Her health deteriorated, and Gail's name was placed on the wait list for a new heart. She waited for a miracle and it eventually came - a new heart.

"My life almost came to a screeching stop...do not let yours!" Gail said. "Research is the key. The American Heart Association and our superb hospitals provide cutting-edge information and technology on prevention. Seek information and put into practice that which prevents heart disease."

Gail's experience shows why the American Heart Association and its volunteers are advocating for more research, education and screening to help prevent and cure heart disease, stroke and other cardiovascular diseases, the No. 1 killer of women in Kansas and the United States.



(1)

**Testimony for the House Health and Human Services Committee,  
SB 25 Kansas Clean Indoor Air Act, March 10, 2009.**

**Thomas Schultz, MD  
Associate Professor  
Associate Program Director, Internal Medicine Residency Program  
The University of Kansas School of Medicine-Wichita**

I am Tom Schultz, Associate Professor with the University of Kansas School of Medicine – Wichita. Thank you for allowing me the honor of providing my testimony to you in support of Clean Indoor Air legislation. Let me first dispense with the numbers:

- Lung cancer is the leading cause of cancer deaths in the US and in Kansas.
- In 2005, 1851 new cases of lung cancer were diagnosed in Kansas. In that same year, 1641 Kansans died of lung cancer.
- 80% of all lung cancers are caused by cigarette smoking, and 1-2% of all lung cancer deaths result from exposure to environmental tobacco smoke by non-smokers. In Kansas, this equates to 32 deaths per year.
- A woman who has never smoked has an estimated 24% greater risk of contracting lung cancer if she lives with a smoker.

And the citations:

- Secondhand smoke is classified as a "known human carcinogen" by the US Environmental Protection Agency, the US National Toxicology Program, and the International Agency for Research on Cancer, a branch of the WHO.
- The 2006 US Surgeon General's Report concluded that "the scientific evidence shows there is no safe level of exposure to secondhand smoke", and "the only way to fully protect non-smokers from exposure to secondhand smoke is to prevent all smoking in that indoor space or building. Separating smokers from non-smokers, cleaning the air, and ventilating buildings cannot keep non-smokers from being exposed to secondhand smoke."

That just covers lung cancer, not the chronic lung diseases such as asthma and COPD, which are significantly impacted by tobacco smoke exposure.

With all that being said, we all sometimes view numbers and statistics as dry and mundane: however, these data are anything but, as they directly relate to people, to Kansans. If you look on the internet, you'll find sites disputing these statistics, and that Clean Indoor Air legislation amounts to "The Second Hand Smoke Attack on Smokers". I'm not here today to attack smokers, or to attack businesses where smoking is allowed. I'm here because as a cancer doctor, I see the effects of smoking on a daily basis, and I don't like what I see.

For example, last Friday I had to tell a vibrant 48 year-old that he has inoperable, incurable metastatic lung cancer. The obvious human tragedy aside, think about this in economic terms. This gentleman probably has 6 months to live. Consider the loss of productivity for this state in losing around 20 years of contributions to society. Additionally, it will cost an estimated \$40,000 to treat his lung cancer.

True, he chose to smoke and has done so for 30 years. Even though I personally do not condone smoking, I would not seek to deny anyone the right to smoke. But what about those who choose not to smoke? Shouldn't they (and their children) have the right to go to public places and not worry about smoke exposure? Even if the data on secondhand smoke is marginalized by nitpickers, doesn't it just make sense that exposure to this is not healthy? Most forms of lung cancer are directly linked to smoking; one is not. So what about the non-smokers who get "smoker's" cancer?

How does that happen? Bad luck? Secondhand smoke? Around 30% of adenocarcinomas, usually thought to be associated with smoking, occur in non-smokers. Additionally, these individuals are often chastised by others, including fellow cancer patients, who think their cancer is their "fault" because they smoked. Unfortunately, this view is all too prevalent, as lung cancer does not enjoy the "celebrity" status of breast cancer because it is perceived as being caused by individual choices, i.e. the choice to smoke.

What can happen to people exposed to smoke in the workplace? My wife is a social worker, but she's also an excellent singer. For four years she sang in a smoky environment to help pay for college. She has never smoked a cigarette in her life, but much like a smoker, she always had a cough with black sputum, one day that cough brought up blood. An x-ray showed a suspicious shadow, and a mass could not be excluded. Fortunately, the resulting CT scan was normal, and luckily it just turned out to be bronchitis.

In this case, a tragedy didn't happen, but sadly the outcome isn't always so good. This establishment is now smoke-free, and due to her new job she no longer sings there regularly, and she no longer coughs. Unfortunately, many workers don't have that choice, especially in these economic times where every job is precious.

Thank you for granting me the opportunity to express my views. I urge you to give your full consideration of this legislation. It's the right thing to do for Kansans.

Thomas K. Schulz, MD

21

**Testimony before the House Health and Human Services Committee,**

**SB 25 Kansas Clean Indoor Air Act, March 10, 2009.**

**Teresa L. Carter C.P.A.**

**Mid-Kansas Affiliate of Susan G. Komen for the Cure®**

Madame Chair and members of the committee, I am pleased to provide testimony in support of SB 25. As president of the Mid-Kansas Affiliate of Susan G. Komen for the Cure® I daily encounter women whose lives are being turned upside down by the ravages of breast cancer. I have comforted women who have just received the life changing news of a breast cancer diagnoses. I have held the hand of breast cancer patients as they sat anxiously receiving toxic drugs to kill the cancer cells. I have cooked meals for families whose mothers and wives could no longer care for their family as the noxious drugs sapped their strength. I have comforted husbands as they accepted the fact that they were losing the woman they had planned to grow old with. I have stood at the bedside of my friend as breast cancer took her life, convinced to the end that it was environmental factors that triggered this disease in her body. I have cried with 800 other breast cancer survivors and their 9000 family members and friends at the Komen Wichita Race for the Cure®, as they celebrate their survival and mourned the loss of those who have lost the battle. And I have promised my daughter, who we adopted as an infant, that unlike her maternal birth grandmother who battled breast cancer, she will not have to. But the lack of a Kansas clean indoor air law makes that promise harder and harder to keep.

The Surgeon General has been telling us since I was 8 years old that smoking causes cancer. Smoking increases the risk of many cancers, but its effect on breast cancer is not yet completely known. So every day we do not have a clean indoor air act we continue to gamble with our daughters' health and allow them to be exposed to a known carcinogenic. Every time you allow your daughter to walk into an establishment that is not smoke free you expose her to an environmental toxin that may take her life in the future. The same kind of toxin that my friend feared had triggered her breast cancer and taken her life. We do not allow lead in paint because it might be ingested by a child and cause brain damage, but we allow smoke, that we know causes cancer, to be inhaled by that same child. Why?

I also stand before you today as an asthmatic. My asthma is not triggered by physical activity but is ALWAYS triggered by environmental factors. The two main triggers are ragweed and smoke. Mr. Chair, only God can control the ragweed, but you and this committee can control the smoke. My family and I currently have to make choices about where we go, where we eat and where we shop based on their smoking policy. Picture yourself having a nice dinner at your favorite restaurant and a lovely couple sits down at the table next to you. It doesn't take you long to realize he spilled the whole bottle of aftershave on himself and she took a bath in her perfume. Now, your sweet overpowering neighbor takes out her perfume bottle and every few seconds sprays a fine mist of the heavy scent in your direction. Your eyes water, your nose burns, your medium rare steak, that moments before had the fabulous taste that only Kansas grown beef can have, now tastes something like what an acid laced

HEALTH AND HUMAN SERVICES  
DATE: 03/10/09  
ATTACHMENT: 21

magnolia leaf might taste. Now imagine that you complained to the manager and she told you that there was nothing she could do about it because your scented neighbors are sitting in the "spraying" section. But she can move you over one table. You just pickup up all your food, your drinks, coats, purses, hats, gloves and silverware and move. Oh, and by the way could you please stop coughing, sneezing and gasping you are really causing quite a disturbance. This is what I encounter when I enter an establishment that is not smoke free. Do you think you would return to that restaurant? Probably not, especially if you are like me, after encountering a smoking environment. I am too busy taking breathing treatments, taking prescription steroids that bloat my system, wreck my stomach and cause chaos with my mind, and just plain trying to breathe again to think of a return trip to that restaurant or any other restaurant, store or establishment for at least 2 weeks while I recover.

I know that some people oppose a clean indoor air act because it supposedly imposes on the rights of smokers. But somewhere way back in a government class I was taught that a right only remains such as long as it does not infringe upon the rights of others. Breathing someone else's second hand smoke most certainly imposes on my rights.

We are 10 years into the new millennium and we Kansans have not yet addressed an issue that since 1966 the surgeon general has been telling us is harmful. I say to you today that the time of putting off the unpleasant decision about indoor smoking has passed. It is time for us to pick ourselves up, dust ourselves off and protect the health of our fellow Kansans by passing the clean indoor air act SB25.

Thank you for your consideration of this important issue.



**Testimony before the House Health and Human Services Committee,**

**SB 25 Kansas Clean Indoor Air Act, March 10, 2009.**

**Molly L. Johnson**

**Senior, University of Kansas, Lawrence, Kansas.**

Madame Chair and members of the committee, thank you for the opportunity to provide you my testimony in support of Statewide Clean Indoor Air, SB 25. I am here today because I care about my health and that of my generation. Between being a life long asthmatic and being involved with various health organizations I cannot remember a time when healthy living has not been a priority for me. Although I know there are some aspects of our environment and medical history that we cannot control, there certainly are areas where changes can be made in order to create healthier surroundings for everyone. One such area is creating policy that will improve the quality of air in indoor public settings by removing the health dangers caused by secondhand smoke. I was raised in a non-smoking home, by parents that were adamant about not subjecting me to smoky environments due to my medical condition. At restaurants we were always seated in non-smoking sections, but even that was not enough at times. I always had to carry an emergency inhaler because there was never a guarantee of not being exposed to smoke, even in non-smoking sections.

The Surgeon General has told us for many years that smoking causes cancer and being exposed to secondhand smoke has been proven to cause cancer as well. It does not take too long to notice the difference between smoke free communities and those that still allow smoking indoors. I grew up in Wichita, but moved to Lawrence for college. As I'm sure you all know Lawrence implemented an indoor smoking ban years ago, while Wichita has only done so recently and to a lesser degree. The affects of the clean indoor air in Lawrence had immediate results on my health, more so than I even expected or noticed until returning to Wichita during breaks. During one summer break I was able to find a job at a restaurant and bar in Wichita as a hostess that allowed smoking. I was lucky, I worked at the front door and was able to get fresh air constantly, so my asthma was not as much of a factor. But I also chose to work as a hostess instead of a server so I would not be subjected to constantly smoky air.

We teach our children not to smoke, that it's bad for you. It seems that if this is truly how society feels then much more effort needs to be put into creating public environments where smoke is not a factor. If someone wants to smoke it is their decision, but why do I also have to live with the implications of their decision? In my experiences it seems that if someone is exposed to smoking they are more apt to take up the behavior themselves. Although secondhand smoke causes harm to everyone, it is important to consider the effects of individuals in my age group. First, the people that typically have jobs in industries that allow smoking indoors are around my age. We are always told not to smoke, but then are exposed to it the most at an age when we are making our own choices regarding our behaviors.

It is also important to consider the air quality in bars and clubs. It's no surprise that college students spend time in these places, and providing clean indoor air in these locations should also be a priority. The majority of people I know favor the smoking ban currently used in Lawrence because when you leave you don't reek of smoke and just feel better in general. I also feel it is important to note that even people I know who are smokers prefer and enjoy the indoor smoking ban because it just creates a better environment for everyone.

In closing I want to thank you for looking to the future, and creating change that will be beneficial both to my generation and Kansans in general. I believe it is my right to clean indoor air and I believe you have the power to assure that secondhand smoke will no longer continue to affect my health and that of my generation. Thank you.



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President Susan Bumsted,

Testimony Before the  
Health and Human Services Committee  
S.B. 25: Clean Indoor Air Act  
Support-Written

Chairwoman Landwehr and members of the Committee, the Kansas State Nurses Association has taken formal positions in the past twenty years around smoking prevention, access to cessation, allocation of the master settlement agreement and clean indoor air. All of these have been aimed at supporting public policy that reduces tobacco consumption and the harmful health risks associated with second-hand smoke. S.B. 25 provides for a uniform statewide clean indoor air law which KSNA supports. This piece of legislation may have the greatest health impact of any other piece of legislation passed this session.

In 2006, U.S. Surgeon General Richard Carmona issued the federal government's scientific report, which concludes that there is no risk free level of exposure to secondhand smoke. Secondhand smoke poses an unnecessary health risk forced upon those non-smokers who are in public places where smoking is unrestricted. This public policy debate is about eliminating an unnecessary health risk and protecting those who don't smoke from secondhand smoke.

There are numerous studies and facts available concerning the effects of secondhand smoke on the health of individuals. Nonsmokers who are exposed to secondhand smoke at home or work increase their heart disease risk by 25 - 30% and their lung cancer risk by 20-30%.<sup>1</sup> Breathing secondhand smoke has immediate harmful effects on the cardiovascular system that can increase the risk of heart attack. People who already have heart disease are at especially high risk.<sup>1</sup> The Center for Disease Control recommends that health care practitioners advise all of their clients with coronary artery disease and those at risk for the disease to avoid secondhand smoke.<sup>2</sup>

The effect on children's health is also well documented. Secondhand smoke exposure causes respiratory symptoms in children and slows their lung growth.<sup>1</sup> Children are more vulnerable than adults because they are still developing physically and generally have a

HEALTH AND HUMAN SERVICES  
DATE: 03/10/09  
ATTACHMENT: 23

higher breathing rate, which means they may inhale greater quantities of secondhand smoke than do adults.<sup>3</sup> Each year in the United States, secondhand smoke exposure is responsible for 150,000 – 300,000 new cases of bronchitis and pneumonia in children aged less than 18 months. This results in 7,500 – 15,000 hospitalizations, annually.<sup>4</sup>

Eliminating smoking in indoor spaces is the only way to fully protect nonsmokers from secondhand smoke exposure. Separating smokers from nonsmokers, cleaning the air, and ventilating buildings cannot eliminate secondhand smoke exposure.<sup>1</sup> There is no risk-free level of secondhand smoke exposure.

We, as nurses, believe clean indoor air rises to the level of a “significant health” initiative that calls on state lawmakers to make the decision to protect Kansans from secondhand smoke exposure.

**KSNA acts for your support of a Clean Indoor Air Law for Kansans. Please pass Senate Bill 25.**

References:

<sup>1</sup>U.S. Department of Health and Human Services. The Health Consequences of Involuntary Exposure to Tobacco Smoke: A Report of the Surgeon General. Available at [www.surgeongeneral.gov/library/secondhandsmoke/report/](http://www.surgeongeneral.gov/library/secondhandsmoke/report/)

<sup>2</sup> Williams G.C, Williams, S., Korn, R. (2005). Secondhand Smoke (SHS) deserves more than secondhand attention: Modifying the 5 A’s model to include counseling to eliminate exposure. *Families, Systems & Health*. 23, 266-277.

<sup>3</sup>MayoClinic (2006). Secondhand smoke: Avoid dangers in the air you breathe. Available at [www.mayoclinic.com/health/secondhand-smoke/CC00023](http://www.mayoclinic.com/health/secondhand-smoke/CC00023)

<sup>4</sup>United States Environmental Protection Agency. Respiratory Health Effects of Passive Smoking: Lung Cancer and Other Disorders. Office of Research and Development, EPA. Available at <http://oaspub.epa.gov/eims/eimscomm.getfile?>



(7)

**Written Testimony in Support of SB 25, the Kansas Clean Indoor Air Act**  
**Before the House Committee on Health and Human Services**  
**March 10, 2009**

Today I come to you as the Dean of Academic Affairs at Brown Mackie College – Salina and as a member of the Board of Education for the Salina school district. As an educator my concerns are focused on the future, to help our children negotiate a pathway through the murky waters of today's influences.

I believe with all my heart that no matter how adamantly folks in this room argue for the right to smoke, none want children to take up smoking.

Children look to us for guidance. They don't take up smoking to look younger; they do so to look more "adult-like." No matter how many times we tell them that smoking is bad our actions send a stronger message.

In Massachusetts, a study found that of the towns that enacted very strict bans on smoking there was also a drop of up to 40% of teens taking up smoking. The study credited the very strong messages sent to teens and children in general that each town as a whole is very much against smoking.

This is a complicated issue. It would be disingenuous of me to pretend bar owners won't have some loss of revenue if a state-wide ban goes into effect or to argue that the rights of smokers won't in any way be diminished. To ask that pro-smokers go along with the ban is to ask them to sacrifice.

Yet, it is part and parcel of the American spirit for one generation to sacrifice for future generations. We have seen this in armed conflicts around the globe throughout the history of our nation.

I do not mean to suggest the sacrifices of smokers rise to the level of military service. Yet to the small business owners trying to make a living and to the individuals who light up in the few places left to smoke, the sacrifices resulting from a smoking ban feel very real.

Likewise, elected officials who vote for a state-wide ban can also be said to vote for greater regulation and to some extent against some individual rights. But those officials who vote against a ban, even if in the name of the free market and individual rights, are also voting for smoking.

If a state-wide ban on smoking could have the same effect as those towns in Massachusetts, and we could truly achieve a 40% drop of teens who start smoking – or even 20% - then the savings we provide for our children in healthcare and a greater quality of life will have been worth it.

Phil Black  
118 E. Republic Ave  
Salina, KS 67401

HEALTH AND HUMAN SERVICES  
DATE: 03/10/09  
ATTACHMENT: 24

Date: March 10, 2009

To: Representative Landwehr and Members of the  
House Committee on Health and Human Services

From: Salvador Romero, Kansans for Nonsmokers Rights, Topeka

Re: **Written testimony in support of SB 25, the Kansas Clean Indoor Air Act**

I would like to ask you to ask you to pass SB 25 which would provide all Kansas workers and all Kansas communities smokefree workplaces and public places.

I have worked hard over the past 20 years to get owners and managers in Topeka to adopt smokefree policies for their businesses, not just for the workers in those places, but for all the customers who come in. So many times when I have tried to explain how harmful secondhand smoke is, they have told me that they would like to but that they can't do it by themselves, because they are afraid that they would lose the business of smokers. Many of them think that the only way that they can continue to make money is by allowing people who smoke to pollute the air space of everyone in those businesses.

I have also tried twice to get the City Council of Topeka to pass effective smokefree ordinances. In the mid-80's a group of us were able to get the Council to adopt an ordinance providing some non-smoking areas in restaurants. But we all know that smoke does not stay in the smoking section—it contaminates the whole area when even one person is smoking in a restaurant. In 1999-2000, another group of smokefree advocates asked the City Council to make Topeka a smokefree city. However, that effort only got fast food restaurants smokefree—as if children were the only ones who are hurt by smoking in public places.

Here it is 2009, and we still have many, many Kansas cities where workers are forced to breathe in smoke at their daily job and where many Kansans cannot enter bars, restaurants, clubs, bingo halls, bowling alleys, etc., because secondhand smoke makes them sick.

I had been a bowler my entire life until my doctor made me give it up. He told me I needed to give up smoking for health reasons. He did not realize that the only smoking I was doing came from breathing in secondhand smoke when I was participating on bowling league teams.

I cannot appear today because I had heart surgery this month and I am still recovering. But I would like you to take my letter to heart and remember all of the people like me whose health has been damaged by exposure to secondhand smoke. Please pass SB 25 for the health of all Kansans. It is wrong to expect the people in each city in Kansas to try and get their city governments to pass local ordinances. It is too hard, it takes too long, and some city councils, like the ones in Topeka, do not listen to their constituents on such health matters. A smokefree statewide policy is the job of our state legislature.

Thank you for reading my letter. I live at 217 N.E. Woodruff in Topeka and my phone number is 785-234-5483 if I can provide you additional information.

HEALTH AND HUMAN SERVICES  
DATE: 03/10/09  
ATTACHMENT: 25

TO: REPRESENTATIVE BRENDA LANDWEHR  
CHAIR, HOUSE HEALTH AND HUMAN SERVICES COMMITTEE



FROM: DR. JAMES HAMILTON  
VOLUNTEER CHAIR OF KANSAS GOVERNMENT RELATIONS COMMITTEE,  
AMERICAN CANCER SOCIETY  
KANSAS STATE CHAIR, COMMISSION ON CANCER

DATE: MARCH 10, 2009

RE: SB 25 – CLEAN INDOOR AIR ACT

**LEGISLATIVE TESTIMONY ON BEHALF OF  
THE AMERICAN CANCER SOCIETY AND THE COMMISSION ON CANCER**

- ❖ Health impact
  - Kansas taxpayers spend \$196 million annually for smoking-related health care costs in Medicaid and \$927 million annually on all smoking-related health care costs in Kansas.
  - The Kansas Department of Health and Environment (KDHE) estimates that a Kansas clean indoor air law would save \$21 million annually in hospital charges by reducing the number of heart attacks brought on by secondhand smoke exposure.
  - Access is limited to safe meals in smoke-free restaurants in many areas of Kansas.
  - Secondhand smoke is responsible for the deaths of approximately 53,000 Americans each year.
  - In 2008 in Kansas, 291 unnecessary deaths from secondhand smoke
  
- ❖ Addictive power of nicotine
  - Is smoking a choice, or an addiction?
  - Nicotine is a highly addictive substance.
  - Nicotine is sold by businesses that would be illegal if they dealt with cocaine or marijuana, which are also inhaled, and are in many ways less addictive.
  - Nicotine has increased in cigarettes by over 10% in the last 15 years, a response by the nicotine cartel to pressure of declining market share.
  - Is it fair to foist this addiction onto the general populace through exposure to secondhand smoke?
  
- ❖ Clean indoor air legislation would most likely pass if Kansas allowed ballot initiatives
  - A statewide poll conducted by the American Cancer Society in February 2009 indicates that 71% of Kansans support a statewide comprehensive clean indoor air law in their state.

HEALTH AND HUMAN SERVICES  
DATE: 03/10/09  
ATTACHMENT: 26

- An astounding 94% of Kansans surveyed feel secondhand smoke exposure is a health hazard and that everyone has the right to breathe clean air in public places and at work.
- ❖ Economic impact of comprehensive clean indoor air laws in other states found to be positive
  - The State of New Mexico reported an 8.2% increase in the hospitality industry in the year following the effective date of their smoke-free law in June of 2007.
  - The Harvard School of Public Health reported 600 fewer fatal heart attacks each year since the Massachusetts Legislature passed their comprehensive state smoke-free law four years ago.
  - Does it make good business sense to base a business model on a declining portion of the population, while alienating 82.1% of the public? (17.9% of Kansans smoke in 2008).
  - Only 4% of establishments in Arizona with liquor licenses listed the impending clean indoor air law as major factor affecting their business before the legislation was approved as a ballot initiative from the people of Arizona.
  - Only 4% mentioned it in a study done by Arizona State University and the State of Arizona after the law went into effect in Arizona - gas prices and the economic slowdown were far more important factors. For more information on the Arizona study: <http://www.azdhs.gov/phs/oeh/pdf/SmokeFreeEconImpactStudy2008.pdf>
- ❖ Legislation needs to be comprehensive for all workplaces in Kansas
  - Smoking-caused productivity losses in Kansas are estimated to be \$906 million annually.
  - Economic times are tough. Job seekers who need to feed their families do not have the luxury of seeking employment in only nonsmoking establishments.
  - No one should be forced to risk premature death and disability from secondhand smoke exposure in an unsafe work environment.

**PLEASE SUPPORT SB 25 FOR A HEALTHIER KANSAS**

*ACS Mission Statement*

*The American Cancer Society is the nationwide, community-based, voluntary health organization dedicated to eliminating cancer as a major health problem by preventing cancer, saving lives and diminishing suffering from cancer, through research, education, advocacy, and service.*

*He-2*





TO: House Health and Human Services Committee

FROM: Chad Austin  
Vice President, Government Relations

DATE: March 10, 2009

RE: Senate Bill 25

The Kansas Hospital Association appreciates the opportunity to comment regarding the provisions of Senate Bill 25, which establishes a statewide clean indoor air law. KHA and its members strongly support this legislation.

Tobacco is the number one source of preventable disease worldwide and is responsible for an estimated 438,000 deaths, or nearly one of every five deaths, each year in the United States. As health care providers, we feel it is necessary to take a stand to stop the use of tobacco. Second hand smoke, and most recently "third hand smoke", has been proven hazardous to people's health. Several reports, including the one issued by the U.S. Surgeon General in June 2006 state that "*there is no risk-free level of exposure to secondhand smoke. Nonsmokers exposed to secondhand smoke at home or work increase their risk of developing heart disease by 25 to 30 percent and lung cancer by 20 to 30 percent*". The report, *The Health Consequences of Involuntary Exposure to Tobacco Smoke*, also cited that second-hand smoke exposure is a known cause of sudden infant death syndrome, respiratory problems, ear infections, and asthma attacks in infants and children.

In a statewide public opinion poll conducted in December 2008 by the ETC Institute on behalf of KHA, 75 percent of the respondents indicated that they would support a statewide smoking ban in all indoor public places. Of the 25 percent that answered in opposition, 40 percent indicated that they would support a partial smoking ban. The results of the poll demonstrate that overwhelming public support for a statewide indoor smoking ban does exist.

Kansas hospitals have been smoke free facilities since 1994. The implementation of that law took time; it was, after all, a culture change. The same will be true with the passage and implementation of SB 25. It must not be forgotten that tobacco use is not a right; it is a privilege that should be restricted when it is detrimental to others. Senate Bill 25 will help Kansas become a more healthy and safe environment. We appreciate your leadership and support on this major health issue and encourage your passage of SB 25.

Thank you for your consideration of our comments.

HEALTH AND HUMAN SERVICES  
DATE: 03/10/09  
ATTACHMENT: 27

28

My name is James Hanus and I am an oncology certified nurse from Lenexa, Kansas. I am also the Kansas State Health Policy Liaison for the Oncology Nursing Society which has 37,000 oncology nurses nation wide and 300 in Kansas. I am writing in support of Senate Bill 25.

As an oncology nurse I know first hand the scourge that tobacco related disease has on patients and their families. Tobacco is the leading cause of preventable disease, disability and death in the United States.

The danger of smoking was first officially stated by the U.S. Surgeon General in 1964 when the public was warned about the health threats posed by tobacco use and the Surgeon General specifically stated that smoking causes cancer.

The U.S. Surgeon General in June, 2006 released a report entitled "Health Consequences of Involuntary Exposure to Tobacco Smoke". That stated that nonsmokers who are exposed to secondhand smoke, at home or at work increase their risk of developing lung cancer by 20% - 30%. The report showed that secondhand smoke causes about 3,000 lung cancer deaths among nonsmokers in the U.S. each year.

According to the American Cancer Society's (ACS) publication "Cancer Facts and Figures 2008", tobacco use in the United States is responsible for nearly 1 in 5 deaths. The ACS report also concluded that tobacco use and exposure to secondhand smoke are causally related to a wide variety of cancers, including cancers of the cervix, esophagus, kidney, lung, oral pharynx, larynx, pancreas and stomach. The ACS also has determined that the annual costs of smoking in the nation costs \$167 billion in health care expenses and lost productivity.

As I result I support the provisions of SB25 that will ban smoking in the places that are currently listed in the bill. However, I would advocate that you would strengthen the bill by allowing no exceptions, except for tobacco shops. I strongly support the provisions requiring employers to provide a smoke free workplace and the provision to prohibit smoking at the access points to all buildings so that employees, customers and guests don't have to walk through a cloud of second hand smoke in order to enter a place of business. The provision to prevent smoking in any private residence that also serves as a day care facility is something that is long overdue to protect young children from the effects of second hand smoke.

I would recommend that the penalty provisions of the bill be strengthened to double the penalties for each violation. Also the penalties for those under age should include a suspension of the individual's driving privileges for 30 days, since it is already illegal under Kansas law for those individuals to be in possession of cigarettes.

On behalf of myself, and oncology nurses in Kansas and across the country I urge you to pass SB 25. The passage of this bill will ensure the protection of the residents and visitors to Kansas from the unnecessary health risks posed by smoking and secondhand smoke exposure.

James I. Hanus, RN, BSN, OCN, MHA

HEALTH AND HUMAN SERVICES  
DATE: 03/10/09  
ATTACHMENT: 28



To: Representative Brenda Landwehr, Chair, and  
Members House Health and Human Services  
Committee.

From: Debra Zehr, KAHSA President

Date: March 10, 2009

### **Written Testimony in Support of Senate Bill 25 – The Clean Indoor Air Act**

Thank you, Madam Chair, and Members of the Committee, for this opportunity to provide written comments on Senate Bill 25. The Kansas Association of Homes and Services for the Aging represents 160 not-for-profit long term care provider organizations through out the state. Over 20,000 senior Kansans are served by our members, which include retirement communities, nursing homes, assisted living facilities, senior housing and community service providers.

We support the Clean Indoor Air Act which would remove tobacco smoke in enclosed public places. Several studies have shown public smoking bans to be effective in reducing levels of heart disease in communities embracing such bans. Recently, a study endorsed by the Centers for Disease Control claimed a 41% reduction in hospitalizations from heart attacks over a three year period in Pueblo Colorado. The policy embodied in Senate Bill 25 could significantly reduce costs to the state health insurance plans and the Medicaid program.

HEALTH AND HUMAN SERVICES  
DATE: 03/10/09  
ATTACHMENT: 29

KAHSA supports the exemption of certain sections of Adult Care Homes from this ban.

Thank you. I would be happy to respond to questions. Please feel free to contact me at Ph: 785-233-7443, or by email at [dzehr@kahsa.org](mailto:dzehr@kahsa.org).

29-2





**Kansas Respiratory Care Society**  
*An Affiliate of the American Association for Respiratory Care*

March 10, 2009

**Written Testimony in Support of SB 25-Kansas Clean Indoor Air Act**

**Before the House Health and Human Services Committee**

**Dear Madam Chair and Members of the Committee:**

I am writing in support of Senate Bill 25 regarding prohibiting cigarette smoking in public places.

The Kansas Respiratory Care Society is a professional organization representing the 1,500 respiratory therapists in the state of Kansas. As respiratory therapists, we work daily with people suffering from lung diseases, ranging from premature infants, to children with asthma or cystic fibrosis, adults with chronic lung disease such as emphysema or chronic bronchitis.

All Kansans deserve protection from second-hand smoke exposure. Those Kansans who already suffer from lung disease or other health conditions should not have to put their health at risk by exposure to smoke. Recent statistics from the American Lung Association have shown that 12% of our citizens have been diagnosed with asthma, emphysema, chronic bronchitis and lung cancer. They deserve the right to breathe clean air.

As respiratory therapists, we see patients who come to our emergency department with an acute asthma attack often triggered by inadvertent exposure to cigarette smoke. We talk to frustrated parents who restrict their children's activities, unable to protect them from second hand smoke and fearful of risking another illness.

The best solution for all of our citizens is to have a consistent statewide statute that provides the protection that all Kansans deserve. On behalf of the Board of Directors of the Kansas Respiratory Care Society, I urge you and your committee to support SB 25.

Sincerely,

Debbie Fox, MBA, RRT-NPS  
KRCS Patient Advocacy Chair  
649 N. 159<sup>th</sup> East  
Wichita, KS 67230  
(316) 210-6458

cc: KRCS Board of Directors

HEALTH AND HUMAN SERVICES  
DATE: 03/10/09  
ATTACHMENT: 30

31

# KANSAS FAITH ALLIANCE FOR HEALTH REFORM

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**Written Testimony in Support of SB 25, Statewide Clean Indoor Air**

**Before the House Health and Human Services Committee**

**1:30 p.m., March 10, 2009**

**Docking Building, Room 784**

**The Rev. Craig Loya**

Madam Chair and members of the committee, I submit this written testimony in support of SB 25 on behalf of the Board of Directors of the Kansas Faith Alliance for Health Reform. I am Craig Loya, Campus Missioner for the Episcopal Diocese of Kansas. I have primary responsibility for the campus ministry at Kansas State University, Wichita State University, and Emporia State University.. The Faith Alliance represents a group of Clergy, conference leadership, and lay persons from sixteen faith traditions. We now have over 120 members from across the state who share a vision of equitable access to health care for all people of Kansas. The Faith Alliance was organized two years ago to advocate collectively for a health care system guided by ethically acceptable policies. We appreciate this opportunity to provide comments in support of Senate Bill 25: a statewide approach to reducing the harmful health consequences of tobacco use in Kansas.

With our long-term health care reform objectives perhaps beyond our reach in the current economic downturn, we insist that other cost prevention and health promotion initiatives must be adopted. Legislation to ensure smoke-free public spaces is a practical step that has proven positive outcomes.

We urge the Committee to consider the scientific, health, and population survey data gathered and presented by supporters who are testifying for passage of this bill. We will not repeat the evidence connecting smoking with preventable illnesses, premature death and costly economic consequences.

We believe that our voice is best used to express grass roots interests and local community perspectives of people living and working in Kansas. We believe that the city by city and county by county adoption of these health-motivated initiatives is gaining momentum and will eventually cover the vast majority of the state's population. However, these regulations will not be consistent and we believe that this is an inefficient means and a more costly method of adopting a policy that surveys reveal are supported by a majority of Kansans. Framing this issue around county and city decision-making

Kansas Faith Alliance for Health Reform  
534 S. Kansas Avenue, Suite 1220  
Topeka, Kansas 66603  
<http://kfahr.org>

HEALTH AND HUMAN SERVICES  
DATE: 03/10/09  
ATTACHMENT: 3 /

authority implies that this is solely a business and marketplace concern rather than a public health policy issue which we believe is paramount.

The perceived fear of business disruption, new costs or declining revenue with the adoption of smoke free establishments is not borne out in practice. However, if there were a competitive disadvantage of having different rules every few miles throughout the state, this will not occur if we create a uniform policy on clean indoor air statewide.

Most Kansans, we believe, to not interpret this bill as a threat to the authority of local businesses, public and private establishments who are trying to accommodate the perceived demand for smoking privileges' among their patrons and workers who smoke. They are more receptive to the promise of smoke-free places for the majority who are non-smokers. Those who are most supportive of this bill interpret the absence of a smoke free policy as an infringement on the rights of the 82% of Kansans who do not smoke.

Finally, from annually conducted nationwide surveys, including results specifically from Kansas, we know that over 50 percent of current smokers report having tried to stop smoking in the past year. This is encouraging, but demonstrates that although unhealthy and costly tobacco is highly addictive. If we fail to adopt this bill, we are missing one opportunity to help persons who wish to break the addiction to tobacco. By limiting the locations where smoking is welcomed and by ensuring that public meeting places and work sites were smoke free, we are offering important community support for breaking personal smoking habits.

The Faith Alliance plans to remain involved with this and other health reform issues as they are addressed during the session. It is our pledge to keep our members and their friends and colleagues informed about these Kansas health reform deliberations. We will also be praying for the newly appointed Secretary of Health and Human Services and reasonable movement on health reform at the national level. Mr. Chairman, we thank you for the opportunity to submit our recommendations and for your consideration of this important legislative proposal.



Date: March 10, 2009

To: Madam Chair and Members of the House Health and Human Services Committee

From: John Neuenswander, Director of Advocacy  
American Lung Association of the Central States

Re: Written testimony in support of SB 25-Kansas Clean Indoor Air Act

The American Lung Association is the premiere national organization dedicated to promoting and protecting lung health. Our mission is to prevent lung disease and promote lung health. Today we are focused on the Fight for Air and our work is accomplished through research, education and advocacy.

On behalf of the Board of Directors, volunteers, and staff of the American Lung Association of the Central States in Kansas, I ask that the House Health and Human Services Committee adopt SB 25 to provide for a statewide Kansas law to protect residents, especially workers, from the contaminated air pollution caused by unrestricted smoking in enclosed places.

Secondhand smoke has severely detrimental effects on the health of humans. In the 2006 Surgeon General's report titled, *The Health Consequences of Involuntary Exposure to Tobacco Smoke*, several major conclusions were put forth with the scientific evidence to support them. I would like to share five of those major conclusions with you:

1. The scientific evidence indicates that there is **no risk-free level** of exposure to secondhand smoke.
2. Secondhand smoke exposure causes disease and premature death in children and adults who do not smoke.
3. Eliminating smoking in indoor spaces fully protects nonsmokers from exposure to secondhand smoke. Separating smokers from nonsmokers, cleaning the air, and ventilating buildings cannot eliminate exposure of nonsmokers to secondhand smoke.
4. Children exposed to secondhand smoke are at an increased risk for sudden infant death syndrome (SIDS), acute respiratory infections, ear problems, and more severe asthma. Smoking by parents causes respiratory symptoms and slows lung growth in their children.
5. Exposure of adults to secondhand smoke has immediate adverse effects on the cardiovascular system and causes coronary heart disease and lung cancer.

This report was written by 22 national experts who were selected as primary authors. The report chapters were reviewed by 40 peer reviewers, and the entire report was reviewed by 30 independent scientists and by lead scientists within the Centers for Disease Control and Prevention and the Department of Health and Human Services.

In February the Senate Public Health and Welfare Committee voted the bill favorably out of committee with a count of 8-1, and the Senate also voted in favor of the bill as amended on a count of 26 to 13. The American Lung Association asks that you also vote in favor of this bill as drafted and take the next step forward in protecting our citizens from secondhand smoke.

The facts are clear—secondhand smoke kills. The EPA estimates that 3,000 lung cancer deaths and 37,000 heart disease deaths occur in America each year due to exposure to secondhand smoke. Understanding the importance of public health, 26 other states have put their citizens first by restricting smoking in restaurants and bars. If Kansas follows in their footsteps by passing SB 25, lives will be saved.



39

**Written Testimony before the House Health and Human Services Committee  
in Support of SB25 Kansas Clean Indoor Air Act  
March 10, 2009**

Dear Madam Chair and Members of the Committee:

We know secondhand smoke exposure is a giant public health issue, some even declare it as a right's issue, but in these difficult economic times perhaps it would be prudent to look at this as a financial issue as well.

As Kansas legislators, you have had to make some very difficult decisions in regard to the 2009 budget and you are still trying to figure out how to balance the 2010 budget. As a health care professional for over 30 years, I am not only concerned about our Public Health but our Financial Health as well.

In addition to all the compelling Public Health reasons to limit secondhand smoke exposure consider the following:

The cost to Kansans last year was nearly \$39 million dollars just for health care from exposure to secondhand smoke.

Did you know for Kansas to cover all the health and productivity costs related to smoking Kansas would have to sell a pack of cigarettes for over \$11 each to just break even?

Secondhand Smoke related illnesses are the third leading cause of preventable death, just behind alcohol and smoking.

The key word here is **PREVENTABLE!**

The Surgeon General's Report states the most cost efficient way to reduce costs caused by secondhand smoke is prohibiting smoking in all public places and places of employment.

There are no safe levels of exposure to secondhand smoke.

How much of Kansas' financial health care expenses could be reduced or eliminated if there was a statewide smoking ban, not to mention the health benefits of reduced heart attacks, lung cancer, and fewer teens starting to smoke, all of which cost money is an intriguing question.

Big tobacco companies continue to hide the facts about the harm from tobacco products.

It is time to fight back, if not for our personal health, for our financial health.

Inaccurate information and fear prey on the uninformed and often leads to decisions not in the best interest of everyone involved. This is a Public Health issue. Secondhand smoke costs the state of Kansas precious money that is desperately needed.

Secondhand smoke kills and we can no longer turn our heads and pretend this isn't an economic issue that is costing all Kansans their public health as well as their financial health.

Bobbi D. Sauder, MSN

Clean Air Emporia

HEALTH AND HUMAN SERVICES  
DATE: 03/10/09  
ATTACHMENT: 33

March 10, 2009

**Written Testimony in Support of SB 25 Kansas Clean Indoor Air Act**

**Before the House Health and Human Services Committee**

Dear Madam Chair and Members of the Committee,

My name is Marcy Morris, and I am the Mother of Zachary Morris. I am writing in support of SB 25.

Zachary is a twin and was born 6 ½ weeks premature. He is a wonderful, fun-loving ten year old now, but suffers from severe asthma. Fortunately, his twin does not have asthma. Each day is spent trying to manage Zachary's asthma at home and at school. Second-hand smoke is always a concern of ours. We do not support businesses that allow smoking but unfortunately, there are still many of them in our great state. The Wichita ordinance proves to be very confusing to us. I first must check and see if the business I am about to take Zachary to is smoke-free so that I don't have to worry about him having an asthma attack there. It would certainly be simpler, safer, and easier for everyone if Kansas had a comprehensive ordinance that prohibits smoking in all public places and places of employment. Indeed, there are many places in Kansas we have to be careful of, as smoking ordinances are not in place to protect Zachary. Going to an outdoor mall is not an option for us. There are people walking around smoking and they often trigger an asthma attack for him. Many times I have walked him through second-hand smoke to take him into the Doctor's office and once inside, he has to stop and use his inhaler in order to go forward to the Doctor's office. It's sad to think that other people can inflict harm to innocent children. It should not be allowed, and I am asking you to support SB 25 so Zachary and others can breathe the clean air they deserve.

On a different note, my husband works in Wichita, where they have a non-comprehensive smoking ordinance. His employer provides a smoking room for its employees. Employees enter the building and pass directly through the smoking room in order to get to their work areas, thus exposing their health to second-hand smoke. I believe a comprehensive statewide ordinance would protect all employees as no one should be forced to begin their day by walking through deadly tobacco smoke.

The Surgeon General's report completed in 2006 showed that scientific evidence supports the claim that second-hand smoke is not safe at any level. Kansas is desperately in need of a comprehensive statewide smoking ordinance that protects the health of its citizens.

Please support SB 25 so all Kansans have the opportunity to breathe clean air.

Sincerely,

Marcy Morris  
421 Berry  
Rose Hill, KS 67133  
316-268-7371 (work)  
316-655-4762 (cell)  
316-776-0732 (home)

HEALTH AND HUMAN SERVICES  
DATE: 03/10/09  
ATTACHMENT: 34

21

SKAETS STEAK SHOP  
2300 N. Main  
Hutchinson, Kansas 67502  
620-662-9845

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Written Testimony in Favor of SB 25, the Kansas Clean Indoor Air Act  
for the Kansas House Committee on Health and Human Services  
March 10, 2009

Dear Chairwoman Landwehr and Members of the Committee:

I am writing to you in support of bill SB25. I have experienced the suspense of Hutchinson passing a non smoking law, heard pro's and con's from our customers, and lived through the fears of the un-known results of the smoking ban.

Since 1947, Skaets Steak Shop has been a favorite local neighborhood family café in Hutchinson, KS. Many generations of families frequent Skaets on a daily basis, some we see two to three times daily. Skaets is located next door to the Kansas State Fairgrounds which generates extra business when there are special functions, especially during the annual State Fair in September.

As the owner of Skaets Steak Shop for over 33 years I can testify to what I know second hand smoke to truly be. "Second hand smoke" does not really describe how disgusting it really is. It is spending free time or down time cleaning and painting the ceilings and walls up to 3 times per year because the nicotine stained the metal. While cleaning, the brown nicotine would run down our arms and smell like something rotten. The towels were a very dirty brown and had to be trashed. There can be no doubt in my mind that was on the ceiling and what was running down our arms is also being absorbed in our bodies and lungs.

With this information, I urge you in the name of thousands and thousands of people that are working in these conditions in the State of Kansas to support SB25. We all know from the studies that second hand smoking is bad for our health. Then why are we allowing the people that can least afford medical bills and loss of work that is related to illnesses from second hand smoke to work under these conditions?

In conclusion, after the smoking ban in Hutchinson, business is booming and we have been able to upgrade knowing that it will not be ruined from the smoke damage. We continue to see new faces daily and Skaets have become a reputable icon in Hutchinson.

Cordially,



Donna Bartholomew  
Skaets Steak Shop



Peppers, Inc.

HEALTH AND HUMAN SERVICES  
DATE: 03/10/09  
ATTACHMENT: 35

34

**Date:** March 10, 2009

**To:** Madam Chair and Members of the House Health and Human Services Committee

**From:** Aubrey Patterson, Respiratory Care Shift Supervisor  
Wesley Medical Center, Wichita, KS

**Re:** Written testimony in support of SB 25-Kansas Clean Indoor Air Act

On behalf of myself and 82% of all Kansans who are non-smokers, I urge you to support our right to clean air in public accommodations. After Wichita recently passed a ban on most indoor smoking, I was able to take up the game of bowling again after 30 years without the annoyance of clogged sinuses and smelly clothing. Allowing smoking in public places denies people like me, who are sensitive to tobacco smoke, from enjoying such activities. I went to the Dog Track a few times after it first opened up, but the experience was always spoiled by three or four people smoking and fouling the air for everyone else. As you know, the Dog Track is now closed. I can't help but feel that one of the reasons attendance was so low was the lack of clean air to breathe. As your constituent, I urge you to pass this act without exceptions, because if a casino does open up close by, I won't be going there to gamble if I have to breathe polluted air to do it. Smokers are not the only people who gamble. I do not patronize the local comedy club because they advertise that they are smoker-friendly, which means they are unfriendly to everyone else.

Studies have shown that tobacco bans do not hurt casino business. In fact, gambling incomes increased in Massachusetts, Maryland and California after smoking bans took effect, and had no effect in Nevada.

All polls on this issue show overwhelming support for the ban on indoor smoking in public places. On behalf of the citizens of Kansas, and as a health care worker who sees the devastating effect smoking has on human lives, I ask that the House Health and Human Services Committee adopt SB 25 to provide for a statewide Kansas law to protect residents, especially workers, from the contaminated air pollution caused by unrestricted smoking in enclosed places.





Tobacco *Free* Kansas Coalition, Inc.

March 10, 2009

**Written Testimony in Support of SB 25  
Before the Kansas House Committee on Health and Human Services**

Dear Chairwoman Landwehr and Members of the Committee:

I am Mary Jayne Hellebust, Executive Director of the Tobacco Free Kansas Coalition. The Coalition stands in support for SB 25, the Kansas Clean Indoor Air Act because secondhand smoke in workplaces is a health hazard.

The passage of SB 25 would be a great step forward for public health in Kansas. A strong, simple and fair clean indoor air law is an effective and no cost way to save lives in Kansas, improve the health of all Kansans, and reduce the huge medical costs caused by smoking and exposure to secondhand smoke. A strong, simple and fair clean air law would provide an effective and economical way to improve the health of Kansans. Such a law would help curtail treatment costs for the lung cancers, heart attacks, strokes and chronic obstructive pulmonary diseases now caused by smoking. Lung cancer rates have not decreased in Kansas over the past years.

Thirty-seven states currently have smoking regulation laws for workplaces, some protecting more workers than others. Twenty-four states restrict smoking in bars and restaurants as does Washington, D.C. The trend across the states is to promote smokefree laws that protect all workers in all workplaces, including bars and restaurants and recreational establishments. Currently, 70.2% of the U.S. population is covered by some type of state or local policy. Workers not covered are usually those with limited education and low salary levels, often in blue collar or hospitality service jobs, many of whom depend on state resources for health coverage. Currently almost \$200 million in state funding goes toward Medicaid costs to treat Kansans for tobacco-related diseases, some of which are directly related to secondhand smoke damage.

We tend to discount what happens on the coasts, but Illinois, Iowa, Minnesota, Ohio, Montana, Nebraska, and Utah have passed laws restricting smoking in workplaces, restaurants and bars. Colorado and New Mexico now have smokefree restaurants and bars. Missouri advocates are continuing their smokefree efforts, particularly after Kansas City, MO adopted a comprehensive ordinance. Oklahoma advocates are trying to remove a preemption bill to allow for smokefree policies at local levels. Indiana, South Dakota, Michigan and Wisconsin advocates are continuing their efforts also. In fact, Kansas and Missouri fall into the ranks of traditional tobacco-growing states like Tennessee, Arkansas, Alabama, Mississippi and Georgia that are often controlled by tobacco company interests.

New scientific reports continue to demonstrate the impact of smoking on health—and the resultant costs, which with current budgetary shortfalls are major concerns. Estimates cite between 300 to 600 non smokers in Kansas dying from diseases caused by secondhand smoke each year, with about 4,000 dying from tobacco-related diseases. A comprehensive smokefree law would protect non smokers from exposure to secondhand smoke and assist many smokers to reduce or eliminate their use of tobacco. Passage of SB 25 would also provide a smokefree norm so that Kansas teens would reject becoming the replacement smokers whose health costs negatively impact the economy of our state.

*Information on smokefree laws derived from Americans for Non-Smokers Rights Foundation and the National Center for Campaign for Tobacco Free Kids.*  
Tobacco Free Kansas Coalition Officers:

- |                              |                                    |                           |                                    |
|------------------------------|------------------------------------|---------------------------|------------------------------------|
| President<br>Linda DeCoursey | Vice-President<br>Jon Hauxwell, MD | Secretary<br>Kathy Bruner | Treasurer<br>Terri Roberts, RN, JD |
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HEALTH AND HUMAN SERVICES  
DATE: 03/10/09  
ATTACHMENT: 37



# GACHES, BRADEN & ASSOCIATES

Association Management & Government Relations

825 S. Kansas Avenue, Suite 500 Topeka, Kansas 66612 Phone: (785) 233-4512 Fax: (785) 233-2206

**Testimony of Kansas Dental Hygienists' Association  
In Support of SB 25 – Indoor Smoking Prohibition  
House Health and Human Services Committee  
Submitted by Ron Gaches  
Tuesday, March 10, 2009**

The Kansas Dental Hygienists' Association (KDHA) supports enactment of Senate Bill 25, the statewide prohibition on smoking in indoor public places.

Smoking is a known factor contributing to the prevalence of mouth and throat cancer and other life-threatening disease. Second hand tobacco smoke has also been determined to constitute an added health risk for those who smoke and those who do not. There is no doubt that smoking constitutes a health risk. Smoking in public places constitutes a public health risk.

KDHA believes it is in the public interest to prohibit smoking in public indoor places. In fashioning a specific proposal, the association is accepting of reasonable exceptions that do not inconsistent with the underlying policy that all employees and patrons of publicly available facilities should be entitled to a smoke free environment. Exceptions should be limited.

Numerous Kansas communities have already acted to prohibit or place significant restrictions on indoor smoking in public places. KDHA believes it is in the best interest of public health policy for the Legislature to pass a uniform law applicable to all communities in the state.

Brenda Landwehr, Chairperson  
Dave Crum, Vice chair  
Health and Human Services Committee

Portia Turner, Michelle Wishon, Sarah Bradshaw, Elisabeth Gaither  
– Clean Indoor Air Student Policy Team, KUMC Public Health Policy Project

March 10, 2009

### **Support for Senate Bill 25- Clean Indoor Air**

Representative Landwehr and other distinguished committee members, I want to thank you for this opportunity to address SB-25.

As advocates of clean indoor air, we support Senate Bill 25. Smoking and being around others' smoke are well-known risk factors for lung cancer. In fact, according to Centers for Disease Control and Prevention, "Cigarette smoking causes lung cancer" and "smoke from other people's cigarettes, (secondhand smoke), causes lung cancer as well" ([http://www.cdc.gov/cancer/lung/basic\\_info/risk\\_factors.htm](http://www.cdc.gov/cancer/lung/basic_info/risk_factors.htm)). The CDC website continues to say that "secondhand smoke contains more than 4,000 chemicals, more than 50 of which cause cancer in people or animals. Every year, about 3,000 nonsmokers die from lung cancer due to secondhand smoke" ([http://www.cdc.gov/cancer/lung/basic\\_info/risk\\_factors.htm](http://www.cdc.gov/cancer/lung/basic_info/risk_factors.htm)). One of the ways to decrease lung cancer rates and associated deaths is to decrease exposure to secondhand smoke.

The CDC goes on to say, "In addition to causing lung cancer, secondhand smoke also causes coronary heart disease" (<http://www.surgeongeneral.gov/library/secondhandsmoke/factsheets/factsheet6.html>). In fact, the January 2, 2009 Morbidity and Mortality Weekly Reports (vol 57, no 51) has a report demonstrating reduced hospitalizations for heart attacks in Pueblo, CO after a smoking ban was enacted. ("Reduced Hospitalizations for Acute Myocardial Infarction after Implementation of a Smoke-Free Ordinance-City of Pueblo, Colorado, 2002-2006, MMWR vol 57 no 51, January 2, 2009).

The CDC also states "Children exposed to secondhand smoke are at an increased risk for Sudden Infant Death Syndrome, acute respiratory infections, ear problems and more severe asthma", "There is no risk-free level of exposure to secondhand smoke", and "Eliminating smoking in indoor spaces fully protects nonsmokers from exposure to secondhand smoke. Separating smokers from nonsmokers, cleaning the air, and ventilating buildings cannot eliminate exposures of nonsmokers to secondhand smoke". (<http://www.surgeongeneral.gov/library/secondhandsmoke/factsheets/factsheet6.html>).

Cigarette companies acknowledge the risk of smoking cigarettes and secondhand smoke. This is evident by on their websites, product advertisements, and product packaging. On Philip Morris' website, it states, "PM USA agrees with the overwhelming medical and scientific consensus that cigarette smoking causes lung cancer, heart disease, emphysema and other serious diseases in smokers. Smokers are far more likely to develop serious diseases, like lung cancer, than non-smokers. There is no safe cigarette."

Secondhand smoke is a problem that specifically affects Kansas. According to the Kansas Department of Health and Environment's Tobacco Use in Kansas 2007 Status report, "Approximately 3,900 Kansans die from smoking-related diseases every year and more than 290 Kansans die annually from secondhand smoke" (<http://www.kake.com/news/headlines/18972494.html>). It is important to protect the health of Kansas residents and Senate Bill 25 is a positive step in this direction. This bill calls for a statewide prohibition on smoking in indoor public areas. In addition to improving work areas, SB 25 will help protect Kansas from the effects of secondhand smoke, which can lead to complications including cancer, heart disease, and emphysema. This law may also lower healthcare costs, which could allow money to be used in other areas.

In conclusion, it would be undoubtedly beneficial for Kansas to pass and enforce Senate Bill 25. Thank you for your attention to this important issue and your commitment to the health of all Kansas residents.

HEALTH AND HUMAN SERVICES  
DATE: 03/10/09  
ATTACHMENT: 39

40

**James Dixon Gardner M.D. FACP**  
**Primary Care Physicians of Manhattan**  
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email [gardner@pcpman.com](mailto:gardner@pcpman.com)

Written Testimony before the House Health and Human Services Committee  
In Support of SB 25 Kansas Clean Indoor Air Act  
March 10, 2009

Dear Madam Chair and Members of the Committee: Representing the Kansas Chapter of the American College of Physicians, the Physician members of the Riley County Medical Society, and unofficially the large majority of citizens in Manhattan Kansas, the many nurses and physicians who provide medical care to those rehabilitating from heart attacks, the 90% of patients who see me and were asked if they wanted second hand smoke regulated, I support the S25 Bill to restrict smoking in all indoor places. I encourage each of you to support this and not dilute this with exemptions. Laws of this nature come about when societies are unable to adequately protect the population from the public health problems without them. It has been demonstrated that good ordinances and laws to restrict second hand smoke have as an outcome, less coronary acute coronary disease with its accompanying death, tragedy, limit of peoples capacity to do things, and sadness. These studies which have documented these realities have been well done. The surgeon general report on the adverse effects of second hand smoke is an excellent document and the conclusions and statements in this are not overstatements. I encourage you to read this or delve into the details to convince yourself of the validity of the statement that "no amount of second hand smoke is safe".

As financial issues are currently important additional support for a good comprehensive law to restrict second hand smoke is evident. One simple conclusion comes from the finding of reduction of acute coronary events by 40 % in one well studied community in Colorado. This is only one of a few reported thus far. I assure you that there are substantial costs to everyone when people have preventable acute coronary disease. One additional example was my patient who went to a bowling alley and due to his exposure to second hand smoke had an acute respiratory event that ended up with about a 20,000.00 hospital bill. He is grateful now that he can go bowling with those who are his friends where second hand smoke is now restricted by law. Second hand smoke clearly causes death and disability and horrendous medical bills. I feel these issues are the reason that Blue Cross Blue Shield of Kansas have come out recently with their support of efforts to reduce medical costs by taking action to limit exposure to second hand smoke. Understanding and accepting the fact that second hand smoke is a very bad health hazard is fundamental to the need of and appropriateness of a State wide restriction of this hazard.

Politically it makes sense to look at this problem objectively as a public health hazard problem and not become enveloped in the political struggles of individuals who may be addicted to tobacco or make money in the sale of tobacco or have the perception that limiting second hand smoke might effect them economically. It has been of interest to me to observe the behavior of politicians on this matter as it exemplifies an addictive process our whole society

HEALTH AND HUMAN SERVICES  
DATE: 03/10/09  
ATTACHMENT: 40



has had for many years related to tobacco. I believe citizens really do want politicians who are fundamentally concerned about the life and liberty and happiness of all the individuals in society. Compromises or exemptions to a comprehensive indoor policy some way makes a statement that those promoting or agreeing to these compromises either do not believe the public health principles are true or accurate. Or they do not have the same respect for human life of those who would not be protected by the law. It is impressive to me how many smoking patients I have who have indicated their feeling that the ordinance recently put into place in Manhattan is just and helpful and acceptable to themselves and their personal freedoms.

The attitude and actions of our local Manhattan Chamber of Commerce have been clear and supportive of a State Wide Law to restrict smoking in indoor places of work and public exposure without exemptions. This policy represented a large majority. A smaller majority also supported an ordinance on the local level. This showed there is a fairness to a comprehensive approach in terms of business and competition when administered on a state wide level. But there is also value in the fundamental public health premise on all levels. There were some in Manhattan who felt additional outdoor restrictions were less clear in terms of these principles. These leaders of business and community government felt strongly enough about this to put forth a proposed alternative ordinance to the city commission which would be brought before them in the possible event that the petitioned ordinance which included these outdoor issues would not pass. There was enough effort made to bring all of the issues into the news and advertising venues and campaign environment. It was clear the voting citizens wanted a comprehensive ordinance since the more comprehensive proposal was voted in by the public with a good majority. I would estimate that at least half of the no votes in the final election process were actually yes votes for the alternative ordinance which was also comprehensive as an indoor restriction and only excepted individual homes. You will receive additional testimony in behalf of the S25 from some of these leaders. For some in Manhattan, the political struggles to get such an ordinance in place in Manhattan caused a petition process to be put in place to assure that this issue would be addressed. Past city officials would have the argument that this issue should have the vote of the people or they did not want to offend specific business interests who expressed fear of adverse effects to their business. I guarantee you that these inactions by some of the community leaders caused many to question the wisdom and integrity of leadership when this issue seemed to be so clear cut as a public health problem. Indeed it seemed to me that this process had some adverse effects on some good men torn by more or less political forces. The process of bringing an issue of this nature to the vote of the people was costly of time and energies of many citizens. It was gratifying to me to see that when a society of people want change they can bring this about in a civil manner. Now that this issue has come to the House of Representatives of our State Legislature, I want you to know that the vast majority of people of our region in the state want to have human life respected by taking action to cause every citizen to feel the responsibility of "taking the second hand smoke outside" or restricting second hand smoke exposure of employees or other people who in their daily commerce and work and recreation want to enjoy life without risk of or having an associated disease inflict them due to exposure to second hand smoke.

Please support S25. If there is inclination to want to amend this , please consider taking out of it exemptions. Please do not amend this to make it less effective in removing second hand smoke from indoor venues. I will assure you that the outcome of this issue and the action of

individual legislators will be known to the primary physicians of this state. Before considering any adverse action on this S25, please read carefully the executive report from the surgeon general on the danger of second hand smoke or read the whole report. Please read the study done recently in Lawrence and how this has affected the commerce of that community in a positive way. In essence I encourage you to take the needed time to inform yourself of the reason those that I represent want to have a state wide comprehensive law. Please feel free to call your physician and get his or her feelings and advise.

James Dixon Gardner M.D. FACP  
Chairman of Public Health and Policy committee Kansas Chapter of the American College of Physicians.  
Past President of the Riley County Medical Society and representative on this issue.

President of the Board of the Missouri Kansas Association of Cardiac and Pulmonary Rehabilitation  
Past President of the Kansas Lung Association  
Past President of the Kansas Chapter of the American Heart Association  
Manhattan Township Trustee  
Member of the Board of Tobacco Free Kansas  
Secretary Treasurer of Clean Air Manhattan  
General Internist Manhattan Kansas  
Volunteer Physician Flint hills Free Clinic

PS: I would have liked to have come to the committee meeting and testify briefly as done for the Senate Committee Meeting. I am committed here in Manhattan and could not change these commitments. Please feel free to email me or call if there are any questions related to my testimony.



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March 10, 2009

Written Testimony In Support of SB 25  
Before the Kansas House Committee on Health and Human Services

**RE: Manhattan Area Chamber of Commerce Support of Indoor Statewide Smoking Ban, No Exceptions.**

Dear Chairwoman Landwehr and Members of the Committee:

I am the immediate past chair of the Manhattan Area Chamber of Commerce and still serve on the executive board. I am a business owner. I have also served in different capacities with healthcare issues, the most recently being with the Kansas Health Policy Authority.

This past spring our board took action by a very strong majority to endorse the principle of a statewide ban of indoor smoking, no exceptions. We also by a far narrower margin endorsed the principle of a local ban on indoor smoking, no exceptions. The motivations of our board were focused on some key issues.

First, the debate is no longer about the credibility of health issues related to indoor smoking. The science is clear about the dangers of indoor smoking and the benefits of smoke-free environments. The cost-benefits analysis clearly weighs in on the side of going smoke-free.

Second, it appears inevitable that Kansas will follow the path of other states and countries in attempting to address this issue. Thus our board is concerned about assuring a fair statewide ban that gives no advantage to one business over another. We feel this can be best achieved with no exceptions for any business.

Third, businesses thrive best when there is not a mosaic of laws that differ from one community to another. Differences in these ordinances result in confusion, added costs, and time lost fighting locally about an issue that really should be addressed statewide.

Many of you are aware that Manhattan recently enacted a smoking ban. Two groups, Clean Air Manhattan (CAM), and Citizens for Reasonable Ordinances (CRO) campaigned about this issue and spent well over \$30,000 between them. The argument was not about whether or not to ban smoking indoors in Manhattan. The debate stemmed around what format to do this and to what degree to impact businesses. Though CAM took the day, the real issue is that we wasted time and money on something that should be done at the state level.

I thus urge you to pass SB25, preferably without the 20% exception for Hotels. This bill adheres to our Chamber's principles and you would be doing many communities a favor by allowing them to avoid costly local fights. You will also save lives.

Sincerely,

Jeff Levin

48

March 10, 2009

Chair and Members, House Committee on Health and Human Services  
Kansas State Capitol  
300 SW 10<sup>th</sup> Street  
Topeka, KS 66612

RE: Written Support for SB 25

Dear Honorable Representatives:

I'm writing to express my unwavering support for the passage of SB25, "An Act . . . relating to smoking . . ." The health risks and associated costs of treating people afflicted by an addiction to tobacco are well known, and scientifically documented. So too are the health risks associated with inhaling second hand smoke. The protection of the health of all Kansans is one of the most important responsibilities that your committee bears. Passage will improve the lives of countless Kansans as it will provide for safer and healthier work environments, and public places without any threat from the ill effects of second hand smoke. As any of us who have known loved ones and dear friends who have suffered from lung, throat and lip cancer, heart failure and emphysema, know that we want to protect them from a similar fate.

It is easily understood why loving parents consider it their mission to ensure the health and well being of their children. As legislators you also have a similar mission to all Kansans. As a city commissioner, I work diligently to promote the public health of all residents in Manhattan. I fully supported a clean air ordinance for our city, and I celebrated the passage of the citizens' petition that created our city ordinance banning smoking in public places.

When I eat in a restaurant, health inspectors make sure that I'm not eating the food left on someone else's plate before me. Employees are not forced to drink water remaining in the glasses from those patrons who have left. Yet many Kansans, as customers, or workers, are often subjected to hazardous second-hand smoke in far too many public places. In what manner does this situation protect public health? A complete ban on smoking in indoor public places is a sound, sensible, legitimate step in promoting the health of Kansans. I'm aware that elected officials in several cities are either working to strengthen their smoking bans, as is the case with Salina, or to pass a smoking ban ordinance, as is the case with Junction City.

A state wide smoking ban in public places is a health issue, pure and simple. It deprives no one of their rights any more so than health inspectors deprive Kansans of their rights when ensuring restaurants are clean and safe. SB25 is not prohibition, which always fails. SB25 is a sensible step toward protecting human health from known, and costly hazards. It is time for the legislature to live up its responsibility to promote the health of all Kansan, and to pass SB25.

Sincerely yours,

James E. Sherow  
City Commissioner  
Manhattan, KS

HEALTH AND HUMAN SERVICES  
DATE: 03/10/09  
ATTACHMENT: 42



(15)

**Health and Human Services Committee  
Kansas House of Representatives**

**Written Testimony of Bruce Snead**

City Commissioner  
Manhattan, Kansas

**March 10, 2009**

**In Support of SB 25**

As a Manhattan city commissioner since 1995 and three-time Mayor of Manhattan, I have dealt with local no-smoking ordinances three times. Due to the overwhelming evidence of public health benefits from such laws in other cities and states, I have supported all three efforts, with the most recent one resulting in a petition ordinance passed in November 2008 by our citizens. We are now in the first month of implementation. While it is positive and appropriate for cities to initiate and pass no-smoking ordinances, a statewide comprehensive approach achieves the greatest good and avoids the repetitive debate and delay, and potential inequities of ordinances created at the local level. My reading of this bill indicates it will be more comprehensive in some areas and not in others. A key positive point to be reinforced is the prohibition within a ten foot radius of an access point for doorways, air intakes or operable windows of existing facilities. However, this distance requirement should be extended to fifteen feet to be the same as that required for newly built facilities, and twenty feet would be preferred for both existing and new facilities for reasons of consistency and effectiveness. I also recommend deleting the exemption for a percentage of hotel rooms. Of course, local municipal ordinances which are in place and have more stringent aspects than any state legislation should remain in effect.

Please create and pass a simple, strong, and fair law that builds on the lessons learned at the local level and in other states. Doing so will save lives and reduce health care costs, and will not cause economic hardships. The results across the nation make this clear.



Bruce Snead

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HEALTH AND HUMAN SERVICES  
DATE: 03/10/09  
ATTACHMENT: 43



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**KMS**

**To:** House Committee on Health & Human Services

**From:** Dan Morin  
Director of Government Affairs

**Subject:** SB 25 An Act concerning crimes and punishments; relating to smoking

**Date:** March 10, 2009

The Kansas Medical Society appreciates the opportunity to appear in support of SB 25, (An act concerning crimes and punishments; relating to smoking). The Kansas Medical Society has historically supported public policies at the local, state and federal levels that protect all people from the harmful effects of tobacco smoke.

Given the state's budget woes and subsequent efforts to now find savings in state health care costs, it would seem appropriate to consider the economic benefits of a statewide smoke-free workplace policy. Government can play a significant role in lowering health care costs and can do so by protecting all Kansas residents — including workers in restaurants and bars — from the dangers of secondhand smoke. Comprehensive clean-air public policy will promote a smoke-free work environment within which business owners can seemingly eliminate a variety of associated costs, including higher health, life, and fire insurance premiums; higher worker absenteeism; lower work productivity; and higher workers' compensation payments. The Kansas Health Policy Authority cites a figure of a 40,000 fewer smokers in Kansas (10% reduction), while KDHE estimates 2,160 fewer heart attacks and a \$21 million decrease in hospital charges from heart attacks alone. Cigarette smoking accounts for at least 30% of all cancer deaths.

As an organization composed of members who see the results that tobacco use has on people's health every day we recognize tobacco use is contrary to the mission of promoting and protecting health. It is well documented that tobacco use and health are incompatible and many patients are seen by Kansas physicians for illnesses caused or exacerbated by tobacco use. Any person observing the adverse effects that lung cancer, emphysema, and oral cancer from chewing tobacco can have on the lives of loved ones can surely empathize with those wanting to eliminate such diseases.

According to the Centers for Disease Control and Prevention (CDC), the number of adult cigarette smokers in the U.S. during 2007 had declined for the first time in 4 years prior. Adult tobacco user prevalence was under 20 percent for the first time since tobacco use rates began to fall during the mid-1960s. We believe these encouraging numbers come as a result of successful education programs and the enactment of smoking laws and regulations. More than 30 states

HEALTH AND HUMAN SERVICES

DATE: 03/10/09

ATTACHMENT: 4/4

have passed smoking bans. The Kansas Medical Society urges members of this committee to favorably pass out SB 25.

There is widespread support for this action from the medical community and the public based on strong evidence of the dangers of passive smoking. We can save billions of dollars on a public health policy that costs virtually nothing to implement. KDHE indicates that the passage of SB 25 would have no fiscal effect on its operations and does not believe enforcement of the bill would have a discernable fiscal effect on local law enforcement.

Thank you for the opportunity to offer these comments supporting standards to ensure a safe and healthy environment.



3/10/09

Honorable Chairman Landwehr and Members of the Health and Human Services Committee,

On behalf of Clean Air Kansas, I am urging you to approve the Kansas Clean Indoor Air Act without exemptions. Clean Air Kansas is a grassroots campaign in support of a smoke free Kansas.

I know second hand smoke is a health hazard because I have asthma. I know the sensation when my asthma is triggered which feels like I am trying to breathe through a small straw.

Our desire for smoke free, indoor, PUBLIC PLACES AND WORKPLACES represents a majority view in Kansans which is confirmed by a survey done by the Kansas Sunflower Foundation.

It showed that **71% of Kansas voters overwhelming favor a statewide law prohibiting smoking in all indoor workplaces and public places.**

The survey respondents, **83% of them, believed second hand smoke is a health hazard.**

I'm originally from Iowa which is now smoke free. I attended college and worked in Nebraska which is now smoke free. I have family in Minnesota which is now smoke free. I vacation in Colorado which is now smoke free, but I live and work in Kansas which I wish was smoke free.

These other states have not collapsed under the weight of smoke free restrictions. Their businesses have not fled the borders. There is not a confusing, hodgepodge of individual community smoking ordinances which creates an unlevelled playing field. These states are in fact, better, healthier places to be.

**Everyone in Kansas**, whether you work in a bar, restaurant, private club, business or public place, **deserves the right to breathe clean air.**



**We urge you to approve a smoke free bill in Kansas that covers indoor, public places and workplaces including restaurants, bars and private clubs.**

**[www.cleanairkansas.org](http://www.cleanairkansas.org)**

Joyce Morrison  
Clean Air Kansas  
3021 SW 10<sup>th</sup> St. #302  
Topeka, KS 66604  
877-620-2257

(46)

**Written Testimony in Support of SB 25**  
**before the House Committee on Health and Human Services**  
**March 10, 2009**

Dear Chair and Committee Members,

One of the essential functions of public health is to protect people from health problems and health hazards. We would like to address some of the comments that opponents to SB 25 are likely to make.

First, the issue of personal rights versus public health is usually brought up. The proposed law does not mandate that smokers quit smoking. They have a right to continue to smoke if they choose. However, they do not have a right to contaminate the air where other people are present.

It is the non-smoker's right to be able to enter into any public area – just like it is the right of a disabled person to be able to have access to any public facility. All public facilities are required by the Americans with Disabilities Act to adapt their facilities to meet the needs of the public. Business owners do not have a choice whether they should or should not comply with this law.

Restaurant owners are required to follow safe food handling practices, to protect the health of the public. They do not have an option.

Child care facilities and child care homes must meet certain minimum guidelines and health standards in order to provide safe care for children. They do not have an option to choose whether they want to comply.

Citizens and businesses are not allowed to dump raw sewage or other contaminants into the public water supply. There are rules governing that because it is a public health hazard.

During the pit bull ban discussions in Salina, the commissioners had to consider the rights of the individual versus the protection of the public, and decided in favor of the public.

Just look around you, and you will see people who have been harmed by secondhand smoke. You won't see the 3,000 people killed by secondhand smoke every year in the U.S.

Second, comments will be made that if this law is passed; bars, bingo halls, etc. will have to close. Common sense tells us that people who patronize these establishments will continue to go and will simply step outside when they need a cigarette. Perhaps these bars will see an increase in patronage because non-smokers will feel comfortable in visiting these establishments. Studies published in peer reviewed medical journals have not demonstrated a decrease in business due to clean indoor air laws.

Third, challenges will be made about the science behind the real effects of second-hand smoke. There is no safe level of exposure. Health may even be compromised within thirty minutes of exposure. The body of evidence to support this is overwhelming. Studies done in other cities (including Helena, Montana and Pueblo, Colorado) have demonstrated a significant reduction in heart attack rates since their clean air ordinances went into effect. Information concerning health effects is available on the Center for Disease Control website. [www.cdc.gov/tobacco](http://www.cdc.gov/tobacco) There is new evidence to show that third hand exposure may also be harmful (from old lingering smoke on clothing, furniture etc.).

Sadly, many of our brave military veterans became addicted to tobacco during their service time, and are in poor health. They are often unable to enjoy socializing at veteran's organizations because of the exposure and effect of second-hand smoke on their health conditions.

Kansas was one of the first states to implement public health measures to protect the health of its citizens, and is generally viewed as a healthy place to raise a family. Children who live in communities with strict smoking ordinances are 40% less likely to start smoking. Your vote today has the potential to save lives.

Thank you.

Yvonne Gibbons RN, BSN, MPH Director, Salina-Saline County Health Dept.  
Del Myers RN, BSN, MS Health Educator, Salina-Saline County Health Dept.

48

## House Health and Human Services Committee

### Written Testimony on Senate Bill 25

March 10, 2009

Chairman Landwehr and Members of the Committee,

The Johnson County Board of County Commissioners respectfully requests the Committee pass out favorably Senate Bill 25. On February 5, 2009, the Johnson County Board of County Commissioners voted to support Senate Bill 25.

The Commission believes Senate Bill 25 will lay to rest the debate over local and state efforts to resolve this important public health issue. The Commission is aware of the current status of local variances on smoking regulations and remains supportive of this bill that will provide a uniform application of the smoking ban.

If the committee has any questions, please feel free to contact Johnson County Government lobbyist, Stuart J. Little. Thank you for your time and we appreciate your consideration of Senate Bill 25 and encourage your support.

HEALTH AND HUMAN SERVICES  
DATE: 03/10/09  
ATTACHMENT: 47