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**EXECUTIVE SECRETARIAT  
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Remarks

To 6: Please have response prepared for EXDIR Signature.

Executive Secretary

29 Jul 86

Date

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| TRANSMITTAL SLIP   |                 | DATE<br>July 28, 1986 |
| TO: Mr. William J. Casey, DCI  |                 |                       |
| ROOM NO.<br>7D60   | BUILDING<br>Hqs |                       |
| REMARKS:<br>Attached please find for your review a memorandum recently presented primarily by FBIS employees to Agency safety and health officials. It addresses an issue that transcends the jurisdiction of any individual office or group of offices. |                 |                       |
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| TRANSMITTAL SLIP  |                 | DATE<br>July 28, 1986 |
| TO: Wm. F. Donnelly, DDA & CIA Safety and Health Official   |                 |                       |
| ROOM NO.<br>7D24  | BUILDING<br>Hqs |                       |
| REMARKS:<br>Attached please find for your review a memorandum recently subscribed primarily by FBIS employees. It addresses an issue that transcends the jurisdiction of any individual office or group of offices. |                 |                       |
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| <p style="text-align: right;"><i>ADDA -</i></p> <p><i>We also received a copy of this report from</i></p>   |                 |                       |
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DD/A Registry  
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July 14, 1986

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Memorandum for:

Environmental Health and Preventive Medicine Officer  
Office of Medical Services

From: Individual Agency Personnel

Subject: Regulation of Smoking in the Workplace

Enclosures: (15)

1. Testimony of Surgeon General C. Everett Koop on H.R.4488, H.R.4546, June 12, 1986.
2. Testimony of Lawrence Garfinkle before National Academy of Sciences (NAS), January 29, 1986.
3. Testimony of John F. Banzhaf III before NAS, January 29, 1986.
4. Testimony of John C. Topping, Jr., before NAS, January 29, 1986.
5. Editorial from AMERICAN REVIEW OF RESPIRATORY DISEASE (1986) by Scott T. Weiss.
6. Editorial from AMERICAN REVIEW OF RESPIRATORY DISEASE (1986) by Robert J. Mason.
7. Testimony of Peter Hanauer on H.R.4488, H.R.4546, June 12, 1986.
8. Testimony of Stanton A. Glantz on S.1440, September 30, 1985.
9. American Lung Association news release on Gallup poll, December 5, 1985.
10. U.S. Merit Systems Protection Board notice (April 29, 1986) and news release (May 13, 1986).
11. General Services Administration news release and proposed rule, May 22, 1986.
- 12, 13, 14, 15. Senate bills S.1440 (July 16, 1985), S.1937 (December 12, 1985), House bills H.R.4488 (March 21, 1986), H.R.4546 (April 9, 1986).

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Pursuant to  which identifies each employee's "right to comment on safety and health standards the Agency follows or proposes," the undersigned, for the most part from FBIS, in the interest of achieving and maintaining a wholesome work environment with its obvious implications for morale and productivity, respectfully draw your attention to the health threat and discomfort caused by the virtually unrestricted use of tobacco products in Agency workspace in general and in that of FBIS in particular. In accordance

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with  we bring these hazards to your attention and we look for a timely review and resolution of the problem. We address our appeal to you because of your professional qualifications and because as Environmental Health and Preventive Medicine Officer you are the logical party to advise the Agency Safety and Health Committee and Agency policymakers on this matter so that a uniform clean air policy can be established throughout the Agency.

In our judgment, the workforce has been left unprotected from ambient tobacco smoke, an increasingly recognized threat to everyone and a source of irritation and suffering for many. This situation exists at a time when American society as a whole has come to recognize secondhand, or passive, smoking as a serious hazard.

Given the current state of our knowledge on the magnitude of the threat represented by such smoke and our own personal experiences at various worksites, it is clear that the remedies prescribed in the present regulation on smoking in Agency-occupied buildings and facilities under the heading "Logistics" [redacted] which is nearly identical to current GSA rules, are inadequate.

The legal basis for remedying this problem is a sound one, considering Agency recognition of each employee's "right to work in an environment free of safety and health hazards" [redacted]. We are further encouraged by a July 22, 1983 Office of General Counsel memorandum of law which notes that our Agency is free to adopt what it considers to be an appropriate safety and health policy.

This freedom to act is especially necessary at a time when many concerned persons are looking with hope to the proposed new GSA regulation on smoking in the workplace, which, while a promising development in the general trend toward protecting employee health, would fall short of providing adequate protection. It would allow smoking in "private offices," a concept which, when discussing the movement of tobacco smoke, simply does not exist since smoke flows from private offices into anterooms occupied by secretaries and/or into the increasingly common bay-type work areas, effectively undercutting efforts to keep the air clean in nonsmoking workspace. This predicament is exacerbated by the transportation of smoke, with its unfilterable gases, by air conditioning systems from the sites of origin to all parts of the building, by seepage under and around closed doors separating distinct work areas, by movement between floors through wiring passageways, and between rooms on the same floor via common dead-air space above false ceilings. John C. Topping, Jr., EPA Staff Director of the Office of Air and Radiation, testifying before a National Academy of Sciences Committee on January 29, 1986, discussed the problem in the following terms:

"Efforts to protect the lives of nonsmokers will necessarily involve severe restrictions or bans on workplace smoking, especially in enclosed environments....Significantly protective standards against involuntary inhalation of dangerous quantities of tobacco smoke are not likely often to be met by sequestration and ventilation in most buildings. If we are to achieve tobacco smoke risk levels for nonsmokers no higher than those we tolerate for industrial carcinogens, air exchange rates akin to those found in wind tunnels would often be required."

For FBIS, with its anticipated move to new quarters that will feature even more bay-type workspaces into which numerous private offices will open, the potential for increased suffering should be clear. Moreover, to allow smoking in private offices, while enforcing, say, the proposed GSA ban in general work areas, would bring with it unsavory class distinctions, whereby a relative few would enjoy a license to smoke, heedless of the impact on others.

For the above reasons we urge the Agency to move from its current regulation on smoking--which is based on a model generally regarded as among the weakest in the nation--to one clearly oriented toward providing the healthiest workplace possible for employees, both nonsmokers and smokers.

\* \* \*

We specifically propose that smoking be restricted to externally vented, separately air conditioned smoking rooms, for the convenience of those who wish to smoke indoors and for the protection of those who do not smoke by choice and do not wish to smoke passively. Use of these rooms would be required only when an employee chose to smoke; no one would use the rooms as a permanent office. While some remodeling costs would be incurred, a high material price is already being paid under the current policy that allows smoking, viz. diminished productivity and increased insurance and sick leave costs.

Among the most important benefits that would derive from restricting smoking as here suggested are:

- \* the comfort of most employees and a more healthful setting for absolutely all employees, especially those for whom exposure to even small amounts of smoke causes pulmonary and other airway complications, dizziness, headaches and nausea;
- \* elimination of situations where equal employment career opportunities are passed up or lost because, in practice, an unspoken requirement of a given job is that it be performed in an atmosphere permeated by tobacco smoke;
- \* help for current smokers enrolled in smoking cessation programs, which, judging from Agency notices, are seen as worthy of promotion;
- \* enhancement of the health benefits derived from any fitness facility on the premises;
- \* reduced health, life, fire, and accident insurance costs for both employees and the government, plus a cut in the price of health and life insurance costs for retirees;
- \* avoidance of the organizational and logistical problems inherent in the creation of separate smoking and nonsmoking offices, an idea suggested by some parties.

We view the smoking room proposal as the only viable solution for dealing with the problem at hand short of a complete ban. Necessarily strict, it is clearly in step with a growing tide of proposals, programs, and expert judgments in favor of dealing firmly with the problems arising from smoke in the workplace, including:

\* A series of warnings from the nation's surgeons general, including those of C. Everett Koop, on the health dangers of tobacco smoke and the need of everyone for a smoke-free environment in which to work and live, most recently in testimony of June 12, 1986 before a subcommittee of the House of Representatives. Koop there noted how one of many studies on the dangers of passive smoking identified ambient tobacco smoke as responsible for "more cancer deaths annually than any other agent currently regulated by the Environmental Protection Agency." Elsewhere in the same testimony he cited a study that showed nonsmoking adults exposed to cigarette smoke in the workplace suffering "a decrease in small airways function equivalent to that decrease observed in light smokers."

\* Regulatory actions taken by corporations, municipalities, states, and government agencies, including organizations presently having total bans on smoking in the workplace, such as the U.S. Merit Systems Protection Board, New England Telephone, Pacific Northwest Bell, Union Mutual Life Insurance Co.; and others restricting it in the workplace but preparing to implement total bans on work premises and/or resolving conflicts in ways consistent with recognition of nonsmokers' prior right to clean air: Boeing Aircraft Company and Chesapeake and Potomac Telephone Co., for example.

\* Legislation before the House of Representatives and Senate (S.1440, S.1937, H.R.4488, and H.R.4546) recognizing secondhand smoke as a significant health hazard, acknowledging the individual's right to work in an environment free of smoke, and, in several instances, allowing government agencies to establish rules stricter than those proposed in the bills themselves.

\* The proposed regulation of the General Services Administration, already noted above, which includes language that both sanctions rules stricter than those contained in its own draft and allows for expenditures necessary for achievement of the regulation's end (this is especially significant because the current GSA regulation prohibits "costly alteration" of office space). The new regulation, according to GSA Administrator Terence C. Golden, is part of a program aimed at "total wellness" of government workers.

\* A Gallup poll conducted for the American Lung Association in July 1985, which found that 80 percent of current smokers, 92 percent of nonsmokers, and 89 percent of former smokers believe that employers should either ban workplace smoking completely or restrict it to designated smoking areas.

\* A recent U.S. Public Health Service survey, which showed that 78 percent of those polled believe employers have a right to prohibit smoking at work.

\* A January 21, 1986 FBIS Near East Asia Division memorandum reporting personnel desires for "a vented smoking room with worktables or desks, unless smoking is banned altogether."

\* A June 6, 1986 memorandum issued by the FBIS Quality of Life Subcommittee, Building Group, which recognized ambient tobacco smoke as "a major concern to a large number of employees" in FBIS.

We believe that the foregoing discussion and the supporting documents that follow provide essential guidance for a necessary review of the Agency Safety and Health Program treatment of smoking in the workplace, a review based on the belief that everyone possesses the fundamental right to clean air, a right that exists prior to and takes precedence over any individual's right to smoke. Furthermore, some of us stand ready to collaborate in planning the implementation of the needed reforms.

cc: DCI; OGC; IGO; DDA; DDST; DFBIS; editor, MEDICAL NEWSLETTER



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STATEMENT OF  
C. EVERETT KOOP, M.D.  
SURGEON GENERAL  
PUBLIC HEALTH SERVICE  
U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

BEFORE THE  
SUBCOMMITTEE ON HEALTH AND THE ENVIRONMENT  
COMMITTEE ON ENERGY AND COMMERCE  
U.S. HOUSE OF REPRESENTATIVES

JUNE 12, 1986

Mr. Chairman, Members of the Committee:

I am pleased to appear before you today to discuss the public health aspects of efforts to restrict smoking in Federal buildings.

At the outset, let me note that we defer to the General Services Administration (GSA) in the formulation of public buildings' policy. As you know, the GSA has recently promulgated proposed guidelines similar to those contained in the two bills before your Committee (H.R. 4488 and H.R. 4546). My Office and the Office on Smoking and Health have met on numerous occasions with the Administrator of the General Services Administration and various staff to discuss features of the currently proposed regulations to ensure that nonsmokers' rights are protected to the extent possible.

My expertise is in the field of public health and I would like to express my views about the public health aspects of these measures.

For the past 15 years, the Public Health Service has supported the reduction of nonsmokers' exposure to ambient tobacco smoke. For example, a component within the Public Health Service, the Indian Health Service, as part of its emphasis on disease prevention and health promotion, has recently adopted a policy that all Indian Health Service facilities should be smoke-free environments. Nonsmokers, as you are probably aware, make up more than two-thirds of our adult population. Increasingly, this majority has become more and more vocal concerning their right to breath air that is free of pollutants emitted from burning tobacco. As this majority finds existing administrative procedures for settling workplace grievances unsatisfactory, they are turning to the courts for relief.

I believe such procedures for protection of nonsmokers rights to be adequately justified in the scientific literature. I would like to briefly summarize the Public Health Service's current understanding of the scientific evidence which we feel justifies restrictions on smoking.

The health effects of cigarette smoking have been known or suspected for over 50 years. It was not until the 1950s, however, that a number of well designed epidemiological studies conclusively demonstrated an association between cigarette smoking and lung cancer as well as other cancers. The scientific base linking smoking to various chronic diseases is now overwhelming, totalling more than 50,000 studies. This evidence led scientists to suspect that tobacco smoke emitted into the air of enclosed indoor environments may also have an effect on health. In the 1970s, investigators began to turn their attention to the possible health effects of passive smoking. The early research designs looked primarily at artificial environments and centered on measuring chemical constituents such as carbon monoxide, tars, benzopyrene, nicotine and other substances found in tobacco smoke. In many studies the environments were strictly controlled laboratory exposures.

We know today that cigarette smoke contains over 4,000 known constituents, some five dozen of which are known carcinogens, tumor promoters or initiators. Many of these constituents are found in side-stream smoke in greater concentrations than in mainstream smoke. Some of these are illustrated in Table 1.

Tar, the fraction of tobacco smoke that is usually associated with the carcinogenic process, is 70 percent higher in side-stream than in mainstream smoke. Carbon monoxide is 2.5 times greater; ammonia 73 times; benzopyrene 3.4 times; and nicotine 2.7 times greater in side-stream than in mainstream smoke.

Side-stream smoke is released into the ambient air, resulting in dilution. Nonsmoker (and smoker) exposure is dependent upon the amount of smoke generated, the volume of ambient air, and the type and amount of ventilation of the occupied space.

While absorption of smoke constituents by nonsmokers in smoked filled spaces has not been completely characterized, a recent Japanese report by Matsukura, Taminato and associates using urinary cotinine levels as a marker for exposure, found that some heavily exposed nonsmokers actually absorbed the equivalent of one to two cigarettes per day (Figure 1).

Contaminants from tobacco smoke are found everywhere, in homes, offices, worksites, and other places where people are permitted to smoke. Sometimes levels of these constituents are higher than are allowed in National Ambient Air Quality Standards (NAAQS). Repace and Lowrey, in their 1980 study, found excessive levels of particulate matter from tobacco smoke in every one of the 19 environments where smoking was taking place. Short-term concentrations exceeded levels of National Ambient Air Quality Standards by factors ranging from 1.2 to 10 and more (Figure 2).

Differences in the carcinogenicity of side-stream and mainstream smoke may also exist. Wynder and Hoffmann found side-stream smoke condensate to be more tumorigenic per unit weight in mouse skin assays than mainstream smoke condensate.

The rationale and concern for the possible health effects of passive smoking are well founded in the epidemiological literature on active smoking which has

consistently noted a strong dose-response effect. Data from the major prospective studies have documented a greater than four-fold excess risk of lung cancer for those smokers consuming nine or fewer cigarettes daily. As the level of daily smoking increases so does the lung cancer death rate. Figure 3, extracted from the American Cancer Society study of more than 1 million men and women followed prospectively for 12 years, illustrates the dose-response effect for four levels of daily cigarette consumption. A dose-response effect has also been observed by the length of time one has smoked, an earlier age of initiation, depth of inhalation, and other variables. In short, the greater the overall exposure to tobacco smoke, the greater the health risk.

One study conducted among nonsmoking adults exposed to ambient tobacco smoke noted a decrease in small airways function equivalent to that decrease observed in light smokers. This study population consisted of nonsmoking adults who did not live with smokers but were exposed to cigarette smoke at the workplace.

Nonsmokers who are exposed to tobacco smoke in the air absorb nicotine, carbon monoxide, and other constituents, as do smokers, although, as would be expected, in smaller amounts. The amounts they absorb are dependent on the extent and length of exposure and the quality of ventilation.

In the 1982 Surgeon General's Report on the Health Consequences of Smoking and Cancer, three epidemiological studies were cited that dealt with passive smoking and cancer. The findings of these studies, one each in Japan, the United States, and Greece, indicated that nonsmoking wives of smoking husbands experienced higher lung cancer rates than nonsmoking wives of nonsmoking husbands. In the studies from Japan and Greece the differences were statistically significant, while

the differences in the United States study were not. In the past four years, however, many additional studies have been published (Table 2). Of the 15 studies to date which have examined the link between passive smoking and lung cancer, only three have not shown a positive correlation and several report statistically significant results.

The case control study by Garfinkel et al is particularly important to note, as the investigators designed the study to take into consideration many of the problems found in other studies. These investigators examined 1,175 women with lung cancer from four hospitals between 1971 and 1981. Eight hundred and ninety eight of these women (76 percent) were identified as smokers according to hospital records. Of the 283 remaining women 36 or 12.7 percent were proved histologically to have other than lung cancer and another 113 or 40 percent were found to be smokers upon re-interview. These cases were excluded from the study. In all, 134 cases of lung cancer were available for analysis, and these were compared to 402 cases of colon-rectum cancer which served as controls. All were nonsmoking women. Two findings are significant. Women whose husbands smoked 40 or more cigarettes per day had a two-fold risk of developing lung cancer (1.99) and women whose husbands smoked 40 or more cigarettes per day in the home had a slightly greater than two-fold (2.11) risk of lung cancer. The strength of this study, however, is that the authors were able to eliminate those women from the study pool who were originally misclassified as nonsmokers and all lung cancers were histologically confirmed. A logistic regression analysis showed a significant positive trend of increasing risk with increasing exposure to husbands smoking at home, controlled for age, hospital, socioeconomic class, and year of diagnosis.

Two additional studies, soon to be published, are purported to also show a strong positive correlation between passive smoke exposure and an increased risk for lung cancer. More recently, studies have also indicated that nonsmokers may be at risk for developing coronary heart disease as a result of exposure to ambient tobacco smoke.

In an attempt to provide a public health estimate of the number of lung cancer deaths that might be attributed to passive smoke exposure each year, Repace and Lowery constructed an exposure model which provided that between 500 and 5,000 lung cancers among nonsmokers may result. Even if the lower figure is accepted, exposure to ambient tobacco smoke would represent more cancer deaths annually than any other agent currently regulated by the Environmental Protection Agency.

Finally, two major reviews on environmental tobacco smoke's effect on nonsmokers were published this past month. One by the Office of Technology Assessment and the other by the International Agency for Research on Cancer (IARC) in Lyon, France. The Office of Technology Assessment Staff Report concluded "The epidemiologic evidence from a number of studies is generally consistent with the biologically plausible hypothesis that passive exposure to tobacco smoke can cause lung cancer." The Office of Technology Assessment Report observed that published studies to date, while not free of flaws in methodology and design, particularly in their measurement of exposure to tobacco smoke, do not invalidate the studies, and that the data are sufficient to warrant serious concern because of the number of people in the population who are currently exposed to such contaminated environments. 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 supported this conclusion on the basis of the



characteristics of side-stream and mainstream tobacco smoke, absorption of these substances by nonsmokers, and the nature of the dose-response relationship consistently observed for active smoking and lung cancer. As with the OTA report, IARC appropriately based its conclusion on the basis of the biological plausibility of the association.

Surveys conducted by the Department of Health and Human Services, the American Cancer Society, and even the Tobacco Institute show that the majority of people, smokers as well as nonsmokers, favor reasonable restrictions on smoking in public places including the workplace. In fact, these surveys indicate strong public sentiment favoring the restriction of public smoking. In the survey conducted by the Tobacco Institute, the majority approved of segregating smokers in every one of the public places tested, including trains, airplanes, buses, theaters, eating establishments, and in workplaces and offices.

Last year the Gallup Poll and the American Lung Association in their biennial survey of attitudes toward public smoking found that 75 percent of all adults, including 62 percent of smokers, agreed that smokers should refrain from smoking in the presence of nonsmokers and 79 percent agreed that companies should have a policy on smoking at work. The percent of adults expressing agreement with these two statements increased since 1983 when the survey was first conducted.

More than 40 states have enacted legislation that controls, restricts, or prohibits smoking in public places. Many of the laws address select circumstances such as elevators while many others have enacted "Comprehensive Clean Indoor Air Acts." This legislation has not been enacted for reasons of fire or safety, per se, but to protect the rights of the nonsmoker to breathe clean air.

In a recent review conducted by the Office on Smoking and Health of all state legislation enacted through 1985, 17 states were identified which have enacted legislation relating to smoking in offices and other workplace settings. (Figure 4).

Many address smoking among Government employees or in Government offices. However, 12 also address non-Government settings. California, for example, requires that state departments employing more than 50 workers adopt a written policy providing nonsmokers a smoke-free environment in meetings and at individual work stations. The statutes of Connecticut and New Jersey mandate that employers of more than 50 workers establish and post written rules regarding smoking and nonsmoking within their facilities. Several states impose restrictions on smoking in workplaces not usually frequented by the general public. Minnesota, Nebraska, and Utah have directed their state health departments to establish rules to prohibit or restrict smoking in factories, warehouses and similar places of work.

The legislation, as proposed in the Senate and now the House of Representatives, parallels actions taken by several large corporations, including the Boeing Company of Seattle, Aetna Life and Casualty Company, Texas Instruments and others that have instituted measures whereby smoking is either banned or restricted to designated areas in the workplace.

Mr. Chairman, in summary, I personally believe that sufficient evidence exists to indicate that nonsmoker exposure to ambient tobacco smoke is hazardous to their health, that such exposure can cause lung cancer and probably other diseases, and that we should not delay public health measures to reduce or eliminate exposure to an agent proven to represent a substantial health threat.

Mr. Chairman, this concludes my statement. I will be happy to respond to questions.



## ASH SPECIAL REPORT

### ***National Academy Of Science Hearings On Passive Smoking***

Action on Smoking and Health joined scientists, health professionals, and others in testifying before the National Academy of Sciences (NAS) on the health effects of ambient or passive tobacco smoke. The NAS, an organization chartered by Congress in 1863 to give federal agencies independent scientific advice on technical issues, was asked by the Environmental Protection Agency to study and report on two issues: how can indirect exposure to tobacco smoke be measured, and what are its effects on health? As part of this process, the NAS's Committee on Passive Smoking heard testimony on Wednesday, January 29, 1986, from approximately twenty witnesses, almost half of them associated with the tobacco industry.

Generally, the testimony and views of government officials, representatives of major health organizations, and independent scientists agreed that there is more than enough scientific and medical evidence to warrant action. On the other hand, the opinion of the tobacco industry and the members of a so-called "Indoor Air Pollution Advisory Group"—individuals whose research is funded by the tobacco industry—is that the evidence is weak and the studies flawed, and that the ill effects many people feel when exposed to tobacco smoke could easily be caused by other things.

Because of the importance of this issue and of the proceedings before the National Academy of Sciences, ASH presents this Special Report, which contains excerpts from the testimony before the Committee and from some of the materials referred to.

#### NOTES

1. Materials printed in smaller type are from the actual documents cited. Omissions and footnotes are generally NOT indicated.
2. Materials in larger type are comments or additions by ASH, and should not be attributed to the authors.
3. Items in brackets are footnotes from the original document if the notation "fn." appears; otherwise, they are comments or additions by ASH.
4. ASH regrets that it cannot respond to requests for individual copies of the documents. Requests should be sent to the individual authors or the NAS, 2100 C St. NW, Washington, DC, 20006.

### **Statement of the Coalition on Smoking OR Health**

**by Lawrence Garfinkle, Vice President for Epidemiology and Statistics, and Director of Cancer Prevention for the American Cancer Society**

This *Statement* is of particular importance for two major reasons. The first is that not only is Mr. Garfinkle a very prominent researcher in the area, but also he speaks here on behalf of the three major national health organizations. The second is that the tobacco industry has quoted Mr. Garfinkle—he says misquoted—in a number of their ads about passive smoking (see discussion following the *Statement*).

I am Lawrence Garfinkle, Vice President for Epidemiology and Statistics and Director of Cancer Prevention for the American Cancer Society. I am speaking on behalf of the Coalition on Smoking OR Health, whose member organizations the American Heart Association, the American Cancer Society, and the American Lung Association founded the Coalition in March 1982 to bring smoking prevention and education issues to the attention of legislators and other government officials. I have published two studies on involuntary smoking and lung cancer, one a prospective study and one a case control study, the latter appearing in the *Journal of the National Cancer Institute* in September, 1985. I am pleased to have this opportunity to present the views of the Coalition and myself about involuntary smoking.

Evidence continues to accumulate on the

harmful effects of environmental tobacco smoke. Many people, allergic and non-allergic, complain of the acute effects of exposure to tobacco smoke. In one study of non-allergic persons exposed to environmental tobacco smoke, nearly 70% said they suffer from eye irritation, 30% indicated they experience nasal discomfort, 30% get headaches and 25% develop a cough. Of those individuals who say they are allergic to tobacco smoke, the percentages complaining of various symptoms are even higher.

The relationship of involuntary smoking and cancer has generated the most interest and scientific inquiry. Studies in both Japan and Greece revealed that women nonsmokers married to smokers have higher risks of lung cancer. In the Japanese study, nonsmoking wives of heavy smokers had an 80 percent high-

of risk of acquiring lung cancer, while the Greek study showed nonsmoking wives of heavy smokers had a risk of developing lung cancer three times that of nonsmoking wives married to nonsmokers.

In a case-control study by the American Cancer Society of 134 lung cancer cases and 402 controls, which used four different methods to measure exposure to tobacco smoke, involuntary smoking increased the risk of lung cancer from 13 percent to 31 percent. This overall risk was comparable to that shown by an earlier American Cancer Society prospective study, although the earlier study did not show a relationship between an increased risk of lung cancer in the nonsmoking wife and the number of cigarettes smoked per day by her husband. The latest ACS study *did* show a dose response relationship based on the number of cigarettes smoked by the husband. The risk of lung cancer doubled in nonsmoking women whose husbands smoked 20 or more cigarettes a day at home.

Several investigators have shown that certain chemical constituents in sidestream smoke (including "tar" and nicotine) are found in much greater concentrations than in mainstream smoke. A number of studies have also demonstrated that involuntary smokers have higher levels of cotinine in blood plasma, urine or saliva than nonexposed nonsmokers. Cotinine is a metabolite of nicotine and is considered an accurate measure of exposure to tobacco smoke.

The evidence linking involuntary smoking and lung cancer is growing. At least two additional case-control studies, each with large numbers of nonsmoking lung cancer cases, are in press. Both new studies show essentially the same dose response relationship between risk of lung cancer and exposure to tobacco smoke as described above. Several other large multicenter studies are now underway as well.

In addition, involuntary smoking may also exacerbate symptomatic coronary heart disease. At a recent American Heart Association meeting, report was made of increased risk of death from coronary heart disease due to involuntary smoking. This paper is now being prepared for publication. Although this report is preliminary and additional studies are required to confirm the finding, this could be an even more serious public health problem than lung cancer, as many more deaths would be involved.

After the first studies linking active smoking and lung cancer in the early 1950s, such as the Hammond-Horn study in 1954, it took six years before the American Cancer Society issued its first policy statement on the dangers of cigarette smoking, and even then ACS limited its concerns to teenage smoking. Many said at that time that more proof was needed before the relationship between active smoking and lung cancer could be proved. Speculation about confounding factors such as personality and genetic background impeded those urging initiatives to stem the growing tide of American smokers. Not until the 1964 Surgeon General's report (*ten years* after the Hammond-Horn study) did education initiatives about the dangers of smoking take hold and begin to have an effect on the nation's smokers.

The Coalition believes that the evidence ac-

cumulated to date about the adverse health consequences of involuntary smoking is sufficient to recommend that action be taken to protect the health of nonsmokers in the work-

**"involuntary smoking may also exacerbate symptomatic coronary heart disease .. this could be an even more serious health problem than lung cancer, as many more deaths would be involved."**

place and in public places. Although more research is needed to determine the details of the relationships between nonsmokers' exposure to tobacco smoke and lung cancer and coronary heart disease, the question of whether the involuntary smoker faces a health risk *has* been answered. The risks posed by involuntary smoking may be much smaller than those posed by active smoking, but the potential number of affected individuals is much, much greater. We should take our lesson from the events of the 1950s and 60s. The time to act is now.

The R.J. Reynolds Tobacco Company, in national ads designed to reassure nonsmokers about passive smoking, has quoted Mr. Garfinkle of the American Cancer Society as saying that passive smoking had "very little, if any" effect on lung cancer rates among nonsmokers, and that "passive smoking may be a

political matter, but it is not a main issue in terms of health policy." Mr. Garfinkle has publicly labeled the latter use of his work "scandalous and hypocritical" because it was taken out of context from its original source, and further distorted its meaning for purposes of the advertisement.

The most recent study Mr. Garfinkle mentioned—Garfinkle, Auerbach, and Joubert, "Involuntary Smoking and Lung Cancer: A Case-Control Study," *J. Natl. Cancer Inst.* 75(3):463-469, Sept. 1985—found that the chances of developing lung cancer for women whose husbands smoked were 30 percent higher than for wives of nonsmokers even after correcting for the fact that wives of smokers are more likely to be smokers or exsmokers. When the husband smoked more than a pack a day at home, the woman's risk was over 100 percent higher. The study concluded:

This indicates that lung cancer is very uncommon among women who don't smoke. Their risk is very small. But we've found that living with a smoker and breathing smoky air heightens the chance that a nonsmoker will develop lung cancer, and that the risk increases the more the smoker smokes per day.

## On The Effects Of Passive (Or Involuntary) Smoking By Nonsmokers

by John F. Banzhaf III, Executive Director and Chief Counsel, Action on Smoking and Health (ASH)

Because Action on Smoking and Health is primarily a legal action rather than a scientific organization, and because the major scientific studies in the area had already been fully discussed before the NAS committee, ASH decided to use its limited time to emphasize several common-sense points in its testimony.

My name is John Banzhaf, and in addition to my position as Professor of Law at the National Law Center of the George Washington University, I am Executive Director and Chief Counsel of Action on Smoking and Health (ASH). ASH is a

non-profit tax exempt scientific and educational organization headquartered in Washington, D.C. It is the only national organization concerned solely with the problems of smoking.

ASH is generally credited with initiating the nonsmokers' rights movement by first successfully petitioning for no-smoking sections on airlines, helping to pass the first two state-wide nonsmokers' rights laws in Arizona and South Dakota, and by developing the "THANK YOU FOR NOT SMOKING" sign. Since the very beginning, ASH, which serves as the legal-action arm of the antismoking community, has been involved directly or indirectly in most of the judicial, regulatory, and legislative proceedings related to the problems of protecting nonsmokers from the adverse effects of ambient tobacco smoke. It is

testify.

Although I have a scientific degree from M.I.T., two U.S. Patents, and have published almost a dozen technical papers, and although in the course of my work I have become generally familiar with the scientific and medical evidence related to the effects of passive smoking, my testimony is primarily that of a layman and not a scientist. For these reasons I would like to very briefly address, not the methodologies of performing or evaluating the individual studies, but rather the form the ultimate findings should take to most fairly and effectively fulfill your mandate of making not only a comprehensive but also a clear and understandable report to the public on this important issue.

In summary, ASH has four major recommendations:

**I. That your report forcefully and without equivocation document those short-term health hazards and physical irritations caused by ambient tobacco smoke as to which there is no serious doubt, and clearly distinguish these from the long-term consequences as to which some may have doubt.**

In seeking to determine whether various substances—such as lead from gasoline, workplace chemicals, food additives and residues, and contaminants in drinking water—cause adverse health consequences, it is often necessary to do many large-scale carefully controlled studies; in part because the adverse effects may be masked by the effects of other substances to which there is also exposure; and in part because the effects take so long to manifest themselves. Fortunately, with regard to many of the problems caused by ambient tobacco smoke, the effects are so immediate, so serious, and so overwhelming that no such studies are necessary. In short, the power of tobacco smoke to cause immediate physical reactions in commonly encountered situations among such a large body of people is by itself conclusive evidence of at least some of the health hazards it poses.

For example, it has long been known by allergists and by many other physicians that there are many conditions that make people very susceptible to the concentrations of tobacco smoke they encounter in their daily lives. These conditions include chronic sinusitis, asthma, hay fever, various allergies, chronic bronchitis, emphysema, and other lung conditions, as well as lesser-known conditions. The National Health Survey ending June 1967 estimated that over 30 million Americans suffer from these diseases.

Virtually every allergist and many other doctors know patients with these and other conditions who suffer serious and often debilitating health problems upon exposure to smoke in workplace and social situations. Such situations have been well documented in the medical literature for at least the past 15 to 20 years. Asthmatics who suffered an attack and were forced to seek medical help from drifting tobacco even while seated in the no-smoking section of airplanes, and people whose reaction to smoke was so severe that they had to be taken from an airplane in an ambulance, have been the subject of testimony at the C.A.B. Courts, administrative agencies have, after hearing all of the evidence, ordered restrictions on smoking in the workplace because of the

nonsmokers, and in some situations have even ordered compensation.

Surely the fact that many people with various susceptibilities suffer severe health problems from exposure to ambient tobacco smoke is not open to question, and no further detailed studies are necessary. While attempting to better quantify the number of such people and the nature and severity of their reactions might be useful, it is far from necessary for purposes of establishing this simple fact.

Equally clear is the fact that many—perhaps a majority—of nonsmokers with no particular susceptibilities suffer real physical irritation upon exposure to tobacco smoke in typical social situations. The most common manifestations, in order of decreasing frequency, are eye irritation, nasal symptoms, headache, cough, wheezing, sore throat, hoarseness, and dizziness. Once again this fact is so well known that it is hardly open to any serious doubt or in need of further studies. Indeed, it is so well known that a major brand of eyedrops actually advertises its product for relief from the “red eyes” caused by exposure to cigarette smoke.

In any body or randomly selected group of nonsmokers there are many who can testify from their own experience of the physical irritations they have suffered from exposure to various levels of tobacco smoke (e.g., a recent survey at the U.S. Agency for International Development showed that 63 percent experienced irritation from smoking in their workplace). In such situations detailed scientific studies are unnecessary: the nonsmoker experiences physical manifestations of irritation every time he or she is exposed to sufficient concentration of tobacco smoke; the irritations cease after leaving the smoky situation, and the irritations are of the type known to be caused by some of the specific chemical irritants identified in tobacco smoke. Once again further studies may be helpful, but they are hardly necessary to document the physical irritations many healthy nonsmokers suffer.

Nor can it be doubted that what each of these two groups experience are health problems. They are in many ways the same manifestations suffered by people with colds, flu, and other common health problems that interfere with a person's ability to work, and in many cases even cause absence from work. The relevant federal agencies, and a U.S. District Court, have determined that persons with a particular susceptibility to smoke are “handicapped persons.”

**“the power of tobacco smoke to cause immediate physical reactions in commonly encountered situations among such a large body of people is by itself conclusive evidence of at least some of the health hazards it poses.”**

**II. That, in evaluating the strength of the evidence linking ambient tobacco smoke to long-term health problems such as lung cancer,**

**your report evaluate these studies in the light of the evidence normally required to take action with regard to other suspected public health problems (e.g., industrial exposure, outdoor air pollution), and to the strength of the evidence concerning well-known public health problems as to which action has long since been taken (e.g., lead in gasoline, food additives).**

I can testify from personal experience that a great deal of confusion has occurred with regard to discussions of debated about whether ambient tobacco smoke is a cause of lung cancer. Since your report is designed at least in part to provide information to the lay public—including regulators, legislators, and other officials—it is respectfully suggested that it must take into account the most popular forms of confusion or misunderstanding and directly address them.

The first problem is that many people believe that a scientific proposition such as causation is either “proven” or “not proven”; i.e., that there is some certain and easily determined quantum or standard of evidence that must be met in order to prove the proposition, and that at any lower level the proposition is not proven. In short, they do not realize, as scientists do, that propositions such as causation only tend to be established, and that while increased levels of evidence produce higher and higher levels of certainty, there is no magic or preordained level at which certainty is achieved.

Closely related is the failure of many people to realize that with regard to most suspected public health problems, action must be taken long before one can say that causation has been established to a standard of “reasonable medical certainty” (a standard familiar from civil actions) or “beyond a reasonable doubt” (a standard familiar from criminal proceedings). Indeed to require this very high and incredibly difficult-to-obtain level of evidence before taking any action, particularly with regard to a substance to which millions are exposed, and which is suspected of causing very serious consequences only manifested after many years of exposure, would doom tens of thousands of people to death.

By the same token, it is inappropriate to initiate various regulatory measures based upon nothing more than a hunch or suspicion. It is for this reason that public health professionals together with legislators and regulators have developed a variety of criteria—standards of proof—to determine with regard to various types of problems when it is appropriate to take action. Common examples include foods and drugs, various components of outdoor air pollution, workplace exposure to various substances, and contaminants in drinking water.

To make whatever assessment you may make of the weight and strength of the evidence linking ambient tobacco smoke to long-term health problems such as lung cancer meaningful to governmental officials as well as the lay public, ASH would suggest that your report include two simple and brief sections. One section would simply state the criteria, in terms of the types and conclusiveness of proof, that are generally required in similar or related situations to trigger regulatory action; e.g., by the Delaney Amendment, the uniform cancer policy, OSHA's criteria, and the various EPA cri-

able layman can evaluate the significance of the weight of the evidence relating to ambient tobacco smoke.

Second, it is respectfully suggested that in order to provide some basis of comparison, the weight of the evidence linking ambient tobacco smoke to lung cancer should be compared to the weight of the evidence relating to other well-known issues. For example, since we have taken several very stringent measures to severely restrict lead in gasoline because of its alleged adverse health consequences when inhaled by children, it is reasonable to ask whether the evidence supporting that action is substantially stronger, substantially weaker, or of the same order of magnitude as that related to ambient smoke and lung cancer. Other examples that came readily to mind include saccharin and cyclamates, various contaminants in drinking water, the various components of outdoor air pollution, and substances whose exposure is regulated by OSHA.

Obviously it would not be necessary to compare ambient smoke evidence with that related to all of the above situations or substances, nor to provide a detailed quantitative discussion of the evidence in these other areas. However, it should not be difficult for persons skilled in these areas to provide a few simple comparisons with other well-known substances likewise subject to regulation. It is respectfully suggested that only in this way will the report be truly meaningful in view of the growing public controversies involving this issue. It should be noted that making such comparisons is purely a scientific assessment, and does not necessarily imply that any particular regulatory action with regard to smoking or the other substances is proper, necessary, or appropriate.

**“Surely the fact that many people with various susceptibilities suffer severe health problems from exposure to ambient tobacco smoke is not open to question, and no further detailed studies are necessary.”**

**III. That the report include a discussion of the serious adverse effects on nonsmokers of efforts to heat, cool, and ventilate buildings in which smoking is permitted—including dramatically increased costs and the problems caused by recirculation—drawing upon the work done by ASHRAE.**

In reporting on the exposure of nonsmokers to ambient tobacco smoke, it would seem only appropriate to examine, draw upon, and report to the extent that it is found to be sound, the work done by the American Society of Heating, Refrigerating, and Air-Conditioning Engineers (ASHRAE) in developing their standards for ventilation. After all, ASHRAE, like the NAS, is an impartial professional body that developed these standards and the underlying methodology based upon its very considerable

area. In any event, it seems to ASH important that the public know about this, and its ramifications.

Basically, what ASHRAE set out to do was to determine how often the air in a room must be exchanged in order to maintain minimum acceptable levels of air quality. What they determined is that with regard to most indoor areas, the number of air exchanges per hour (or the amount of ventilation in cubic feet per minute) must generally be three to five times greater if smoking is permitted. Implicit in these standards is the well-known scientific fact that the gases in cigarette smoke (or indeed in any other contaminant) cannot be filtered out of the air; that the particulates in cigarette smoke can be filtered out only to a limited extent; and that much of the air exhausted from a room with conventional ventilation systems is simply recirculated—thus returning most of the cigarette smoke contaminants to the indoor area.

These studies are important for government officials and others seeking to assess the impact of ambient tobacco smoke. They indicate that it costs far more to maintain an acceptable level of air quality if smoking is permitted than if it is not, or if it is permitted only in separately ventilated areas. They also indicate that, particularly for persons with conditions making them specially sensitive to tobacco smoke, prohibiting smoking in their immediate area may not eliminate the problems. A report noting these facts will also help to put nonsmokers on notice that if they suffer from various ill effects in the work environment, they should not rule out tobacco smoke as the culprit simply because no smoking occurs in their immediate vicinity.

**IV. That your report specifically address, evaluate, and report on the alleged reports, quotations, and other materials cited by the Tobacco Institute and the R.J. Reynolds Company in ads as evidence proving that ambient tobacco smoke does not create health hazards for nonsmokers.**

Over the past several years large advertisements sponsored by either the Tobacco Institute or the R.J. Reynolds Tobacco Company have appeared in newspapers and magazines across the country. They address the question of whether ambient tobacco smoke causes health problems for nonsmokers, and

are asserted to be the conclusions of different bodies and the positions of various scientists.

Action on Smoking and Health respectfully suggests that it is not only appropriate but actually necessary for your report to specifically address the purported authorities cited by these two companies in your final report. We believe that this is necessary for at least two reasons. The first is that the cigarette manufacturers and their major spokesperson, the Tobacco Institute, have frequently maintained that evidence tending to support their side of issues related to smoking is unfairly and improperly ignored by various bodies that have reviewed the evidence. Indeed, they seem to maintain that the weight of evidence on the issue of ambient tobacco smoke is on their side, and that conclusions to the contrary can be reached only if the authorities they cite are ignored. Thus, to avoid any controversy of this type with regard to your own report, it would seem useful to at least briefly discuss each of the authorities they have cited, and explain both the weight you attach to them and their impact, if any, on your conclusions.

A second reason why ASH believes that you should at least briefly address these assertions is that they appear to have confused and perhaps even misled many readers. Many people have reportedly seen the ads and no doubt concluded from looking only at the one-sided and self-serving statements therein that there is a significant body of scientific thought to the effect that there are no health problems related to ambient tobacco smoke. Any conclusions to the contrary are likely not to be believed by such readers, unless they specifically address and do not duck the evidence cited by the cigarette manufacturers.

It must be emphasized that ASH does not suggest in any way that your report review the specific ads, nor attempt to determine whether they are in some sense unfair or misleading as some have charged. Rather, what we suggest is that your report specifically address the documents cited by the industry, as you presumably will for other reports and studies, and assess the weight, if any, that should properly be given to them based upon well-established scientific criteria.

## Passive Smoking and the Innocent Victim: A Dilemma for Policy Makers

by John C. Topping, Jr., Staff Director,  
Office of Air and Radiation, U.S. Environmental Protection Agency

This paper, by a government official with extensive experience related to air pollution, summarizes most of the major evidence in this area, and recommends elimination of all smoking in the workplace as a necessary step to adequately protect nonsmokers.

Until recently involuntary exposure to cigarette smoke has been treated more as a matter of social etiquette than of public health. The nonsmokers' rights movement has been portrayed by tobacco interests as an assemblage of finicky busybodies intent on imposing their values on smokers. In the past year the passive smoking issue has taken on new dimensions as evidence has mounted that involuntary exposure to tobacco smoke may be one of the leading environmental sources of death.

of groups such as Mothers Against Drunk Driving, we have become more conscious of the slaughter on our highways caused by alcohol abuse and have taken concrete steps to curb this abuse. Efforts to curb drunk driving have undoubtedly saved lives of persons in each of these categories, sparing the lives of potential drunk drivers, their willing or unwilling passengers, and innocents who would have had the misfortune to come across these drivers on the highway.

**"Involuntary exposure to tobacco smoke may be one of the leading environmental sources of death."**

Our experience in dealing with drunk driving is instructive as we approach a source of death of equal or greater magnitude, passive smoking. Last year Repace and Lowrey projected an annual U.S. lung cancer death rate among nonsmokers from involuntary exposure to tobacco smoke of about five thousand. These projections have gained acceptance in the public health community as indicated by an editorial in the current issue of the *American Review of Respiratory Disease* by Scott T. Weiss, M.D., Associate Professor of Medicine at Harvard Medical School. Repace and Lowrey's lung cancer risk projections appear consistent with the findings of a number of epidemiological studies indicating elevated lung cancer risk from exposure to sidestream tobacco smoke. This five thousand annual projection for lung cancer deaths alone from sidestream tobacco smoke exceeds most current total annual cancer estimates for general population exposure outside the workplace from all industrial carcinogens combined. Yet, while these estimates of lung cancer risk from involuntary exposure to tobacco appear to be the most firmly supported of the passive smoking risk projections, they may represent only the tip of the iceberg of the health damage from such exposure. [fn: Peter Fong, Physics Department, Emory University, has projected that passive smoking exposure of nonsmokers is responsible for between 10,000 and 50,000 deaths annually. Fong, "The Hazard of Cigarette Smoke to Nonsmokers," *J. Biol. Phys.*, Vol. 10, 1982.]

If we are to minimize cancer risks from involuntary exposure to tobacco smoke, further research by health scientists on the specific mechanisms elevating such cancer risk would be desirable. Yet from the viewpoint of policymakers and citizens alike the present evidence, fragmentary though it is, seems sufficient to warrant strong steps to cut down involuntary exposure to cigarette smoke.

Although the greater accessibility of data on family smoking habits and childhood or spousal health provides us considerably greater understanding of passive smoking in the home, there is evidence that tobacco smoke concentration and health risks may be greater in the workplace. James L. Repace, one of the pioneers with A.H. Lowrey in research on passive smoking, summarizes the findings the two have made in a series of studies:

cigarettes, pipes, and cigars indoors was not only chemically related to the smoke from factory chimneys, but routinely occurred at far higher levels indoors than did factory smoke or automobile exhaust outdoors. [Our] controlled experiments and field studies showed that in buildings where tobacco is smoked, substantial air pollution burdens were inflicted upon nonsmokers, far in excess of those encountered in smoke-free indoor environments, outdoors, or in vehicles on busy commuter highways. Daily exposure to ambient tobacco smoke, [we] found, could cause air pollution levels corresponding to violation of the annual National Ambient Air Quality Standard for Total Suspended Particles for exposed office workers, at typical building occupancies and ventilation rates, and amounted to the single most important source of exposure of the population to this harmful kind of air pollution.

Tobacco particulate consists overwhelmingly of respirable small particles. Recognizing that particles of 10 microns or less are readily inhaled into the lungs where they cause respiratory difficulty, EPA has proposed adoption of a health standard keyed to particles of 10 microns or less.

**"[Five thousand nonsmoker deaths a year from passive smoking] may represent only the tip of the iceberg of the health damage from such exposure."**

Some health studies have indicated that passive smoking exposure of adults may significantly increase risks of heart attack. Garland *et al* found in a prospective study of 695 Southern California married women who had never smoked that over a 10 year period nonsmoking wives of current or former cigarette smokers had a higher total and age-adjusted death rate from ischemic heart disease than women whose husbands never smoked. This is not particularly surprising as we know sidestream tobacco smoke includes substantial quantities of carbon monoxide. EPA recently reaffirmed a National Ambient Air Quality Standard of 9 parts per million, 8 hour average, of carbon monoxide not to be exceeded more than once a year. A significant factor in this reaffirmation was evidence that exercising angina patients exposed to elevated levels of carbon monoxide showed more rapid onset of angina pain. In one study, Pimm *et al* (1978) exposed nonsmoking adults to tobacco smoke in an exposure chamber and realized relatively constant levels of carbon monoxide of about 24 parts per million above the ambient level, concentrations three times EPA's 8 hour average carbon monoxide standard for ambient air. Such levels are probably often reached when smoking occurs in enclosed environments with little ventilation such as many taverns, restaurants, banquet halls, closed cars or taxicabs. Within a few minutes elevated carbon monoxide levels in the air which is breathed will be reflected in increased levels of blood carboxyhemoglobin. As blood

carboxyhemoglobin levels rise, the blood's capacity to carry oxygen is diminished, thus increasing risk of heart attack or stroke. Approximately 8.7 million individuals are known to suffer from angina and related cardiovascular disease. These individuals can be presumed to be at special risk from both mainstream and sidestream tobacco smoke.

About 3 percent of the population, many acute asthmatics, bronchitics or atopics, are allergic to tobacco smoke. Such hypersensitive individuals report frequent nose and throat irritation, wheezing, coughing, nausea and sometimes persistent headaches following exposure to tobacco smoke. A much larger portion of the nonsmoking population appears to experience some form of annoyance or distress at involuntary exposure to tobacco smoke. This is especially true of those who have never smoked, about 44 percent of the total U.S. population. In 1979, nearly eighty percent of those who indicated to interviewers that they had never smoked, reported that it was "annoying to be near a person who is smoking cigarettes".

Despite the deep aversion which many nonsmokers have long had at being forced to inhale others' tobacco smoke, until recently they have been on the defensive. A social onus has existed on the nonsmoker who replies negatively to the sometimes proffered plea, "Do you mind if I light up?" Tobacco smoking has moved over three generations from an almost exclusively male ritual focused around pipes and cigars and found generally at salons, prize fights and smoking parlors to a socially pervasive cigarette-based addiction involving all classes and both sexes.

Surgeon General C. Everett Koop has articulated what is a laudable goal, "a smoke free society by the year 2000. Such a policy, fully implemented; would save the lives of thousands of nonsmokers annually. Yet for each nonsmoker's life spared, it is virtually certain that the lives of several smokers will be saved.

**"the present evidence, fragmentary though it is, seems sufficient to warrant strong steps to cut down involuntary exposure to cigarette smoke."**

[ Efforts to protect the lives of nonsmokers will necessarily involve severe restrictions or bans on workplace smoking, especially in enclosed environments. These restrictions will themselves result in some curtailment of tobacco consumption. Moreover, the willpower smokers develop to refrain from smoking when they would imperil others may help them to kick the habit. A high percentage of smokers would like to do precisely that, but because of nicotine or other tobacco-related dependency have not been successful.

Significantly protective standards against involuntary inhalation of dangerous quantities of tobacco smoke are not likely often to be met by sequestration and ventilation in most buildings. If we are to achieve tobacco smoke risk levels for nonsmokers no higher than those we tolerate for industrial carcinogens, air exchange

**by Scott T. Weiss, M.D., Assoc. Prof.,  
 Harvard Medical School**

This editorial from the *American Review of Respiratory Disease* (1986; 133:1-3), referred to by John Topping of the EPA, is important because it summarizes and evaluates the major studies linking ambient tobacco smoke to lung cancer in nonsmokers. Although Dr. Weiss finds that the available evidence does not meet the very strict scientific standards of causality—in large part because of the almost impossible problem of accurately measuring exposure and dosage—he nevertheless cites many reasons for believing the association exists, indicates that most of the studies to date support the association, and concludes that 5000 lung cancer deaths a year from passive smoking is the most “plausible estimate from the current data.” Below are excerpts from this editorial, including the important foot-

notes, and a table summarizing the major articles but omitting his comments on them.

Repace and Lowrey (1) have recently estimated that approximately 4,700 nonsmoking Americans die each year from lung cancer as a result of involuntary tobacco smoke exposure. The purpose of this editorial is to comment on the association between passive smoking and

**“There is no disagreement about the biological plausibility of an association between passive smoking and lung cancer.”**

lung cancer and the biological and mathematical assumptions underlying Repace and Lowrey's assessment of risk.

There is no disagreement about the biological plausibility of an association between passive smoking and lung cancer. Active smoking is unequivocally and causally associated with this disorder. Even at the lowest levels, active smoking is associated with an increase in

Alfred H. Lowrey, “An indoor air quality standard for ambient tobacco smoke based on carcinogenic risk,” *New York State Journal of Medicine*, Vol. 85, July 1985. The authors calculate that ventilation to achieve an acceptable risk from passive smoking would require \$28,000 per smoker, exclusive of fan operating costs. Repace and Lowrey, 382.]

For economic and technical reasons such ventilation would not be feasible. Passive smoking in the home is not and should not be susceptible to government regulation. Family members share a concern for each other which should cause them to adopt more considerate behavior once they have facts on the health risks of passive smoking. Following on the recent, salutary expansion of the health warning on cigarette packages should be added warnings on the risks to nonsmokers of involuntary exposure to tobacco smoke.

Elimination of unwanted tobacco pollution in the workplace and informing the public of the health risks attendant to passive smoking will strike at some powerful economic interests. While the stakes for the public health are enormous in this battle, it would be Pollyannaish to assume easy sledding. If the public is to act intelligently to address this problem, the health science community must speak out clearly. This workshop is an auspicious beginning.

**STUDIES OF PASSIVE SMOKING AND LUNG CANCER**

| Author                             | Reference | Study Design | Country   | Results  | Dose Response     |
|------------------------------------|-----------|--------------|-----------|--|-------------------|
| Trichopoulos and associates (1981) | 7,8       | Case-control | Greece    | + association in nonsmoking females; statistically significant                           | yes               |
| Garfinkle and coworkers (1985)     | 9         | Case-control | U.S.      | + association in nonsmoking females; statistically significant                           | yes               |
| Hirayama, (1981)                   | 10,11,12  | Cohort       | Japan     | + association in nonsmoking males and females; statistically significant                 | yes               |
| Garfinkle (1981)                   | 13        | Cohort       | U.S.      | + association in females; not statistically significant                                  | no                |
| Gillis and associates (1984)       | 14        | Cohort       | Scotland  | + association in males but not in females; statistical significance tested for           | no                |
| Correa and coworkers (1983)        | 15        | Case-control | U.S.      | + association in both males and females; statistically significant                       | yes, females only |
| Kabat and Wynder (1984)            | 16        | Case-control | U.S.      | + association in males but not in females; statistically significant for males only      | no                |
| Sandler and associates (1985)      | 17,18     | Case-control | U.S.      | + association in both males and females; statistically significant for females only      | not tested        |
| Chan and coworkers (1979)          | 19        | Case-control | Hong Kong | No association for females; no statistical significance                                  | no                |
| Knoth and associates (1983)        | 20        | Cases        | Germany   | + association when compared to German population; no statistical significance tested for | not tested        |
| Koo and coworkers (1983)           | 21        | Case-control | Hong Kong | No association for females; no statistical significance                                  | no                |



threshold exists. In addition, sidestream smoke has the same carcinogens and cocarcinogens as mainstream smoke, most at significantly increased concentrations. Thus, although the quantitative smoke is less than that of the active smoker, the qualitative exposure to carcinogens may be the same or greater, and it remains unknown how active and passive smoking differ in terms of actual carcinogens delivered to the respiratory tract. The finding of mutagens in the urine of passive smokers is consistent with the carcinogenic potential of sidestream smoke.

**"The finding of mutagens in the urine of passive smoking is consistent with the carcinogenic potential of sidestream smoke."**

Equally indisputable is the ubiquitous nature of this exposure to passive smoke. Although only 30 percent of adult Americans are active smokers, biochemical indices of exposure, such as urinary cotinine, suggest that the vast majority of nonsmoking adults have at least some exposure, that this exposure is greater than that reported by questionnaire, and that it varies with the number of smokers in the home and/or workplace. Approximately 70 percent of children in the United States live in homes with at least one smoking adult. Despite the increasing information in the field, the episodic nature of exposure, and the imperfect means of measuring this exposure indicate that further research is required to define more clearly who is being exposed and how exposure is best assessed for an individual.

Biological plausibility and the ubiquitous nature of the exposure aside, the scientific studies examining the association between passive smoking and lung cancer (summarized in table) have definite flaws. The bulk of the studies show a positive association (1-18, 20). Compared to active smoking, the association is relatively weak, varying from a 30 to 340 percent increase in risk (odds ratios of 1.3 to 3.4 for exposed relative to nonexposed). Given the nature of the exposure, one would expect the increase in risk to be relatively low. Conventional measures of statistical significance for the association are present in half of the studies (7-12, 17, 18). This is not surprising, given that the increase in risk is small. Several studies (14, 15, 17, 18), all showing a positive association, have too few cases to have adequate statistical power to achieve statistical significance for all comparisons. A dose response relationship is not uniformly present (7-12, 15). These varying results reflect both the small number of cases and imprecise measurement of exposure. Finally, only one study has documented a reduction in cancer incidence with a reduction in exposure (10-12).

Based on the above summary, the existing data on passive smoking and lung cancer do not meet the strict criteria for causality of this association. However, the nature of the scientific problem is such that achieving these strict criteria may be exceedingly difficult, if not impossible.

deaths, roughly 15 percent of which (16,275) were in nonsmokers. Repace and Lowrey (1) estimate that 4,666 deaths/yr, 5 percent of all annual lung cancer deaths and 30 percent of nonsmoker annual lung cancer deaths, are due to passive smoking. They derived this estimate by comparing age-standardized differences in lung cancer mortality rates between Seventh Day Adventists who never smoked, and demographically comparable nonsmoking, non-Seventh Day Adventists. The investigators make many simplifying assumptions, namely, that the entire lung cancer death rate difference is due to passive smoking, that the Seventh Day Adventists are all not exposed and non-Seventh Day Adventists are exposed, that there are no differences between men and women, and that there are no other differences between the 2 groups. Even though these assumptions are overly simplistic, the resulting figure, 7.4 lung cancer deaths per 100,000 person-years, is remarkably close to the estimate from the best available study, that of Hirayama (6.8 lung cancer deaths per 100,000 person-years)(10-12).

An alternative and less satisfactory approach, in my view, is the use of a probabilistic model that is less biologically plausible and based on far greater assumptions about the amount of exposure per-person per-day. This model yielded a roughly tenfold lower estimate, 0.87 lung cancer deaths per 100,000 person-years. Slight changes in the amount of exposure per-person per-day yields a similar estimate to that given in the previous analysis. As pointed out by the

**"Repace and Lowrey's figures remain the best current estimates of lung cancer deaths from passive smoking."**

authors, even this lower figure is tenfold greater than many currently regulated carcinogens(1).

Despite the simplifying assumptions of the risk estimates and the flaws in the epidemiologic data from which they are derived, Repace and Lowrey's figures remain the best current estimates of lung cancer deaths from passive smoking. Current epidemiologic data are sufficiently imprecise to be able to accurately distinguish between the estimate of 500 or 5,000

deaths per year. The higher figure seems a more plausible estimate from the current data. Future epidemiologic studies will allow revision of these estimates but are unlikely to dispute the basic nature of the association.

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## Should Chest Physicians Be Passive On Smoking?

by Robert J. Mason, Dept. of Medicine, National Jewish Center for Immunology and Respiratory Medicine, Denver, Colorado

This companion piece, also from the *American Review of Respiratory Disease* [1986; 133:4], likewise reviews the available medical literature and

concludes that there is more than enough information for all people—especially including chest physicians—to act.

The current focus of public concern is on passive, or secondhand, smoking. The adverse effects that have been reported include increased respiratory infections in infants of smoking mothers, increased lung cancer in non-

smoking women whose husbands smoke, and respiratory irritation among asthmatics and others who are sensitive to cigarette smoke. Side-stream smoke, the smoke inhaled by non-smokers, is known to contain carcinogens, and metabolites of the smoke can be measured in the urine of nonsmokers. Hence, it is extremely likely that side-stream smoke poses a risk of lung cancer in nonsmokers. The major question is the magnitude of the risk. Garfinkle and associates reported a large case control study of lung cancer among lifetime nonsmoking wo-

**“The current data are sufficient for me to conclude that passive smoking carries a significant risk to the public and should be curtailed.”**

men whose spouses smoke cigarettes. The smoking histories of both spouses and the histologic diagnosis of lung cancer were independently verified. There was an increased risk of

lung cancer among nonsmoking spouses whose husbands smoked more than 20 cigarettes per day at home. There have been two previous large epidemiologic studies from Greece and Japan, which found a similar effect,

**“To my knowledge, there is no proven threshold for exposure to cigarette smoke that carries no adverse health effect.”**

although there have been methodologic reservations about these studies. Garfinkle and associates discuss both the positive and the negative data that are currently available. The current data are sufficient for me to conclude that passive smoking carries a significant risk to the public and should be curtailed. To my knowledge, there is no proven threshold for exposure to cigarette smoke that carries no adverse effect. We must take a position against

allowing smoking in public places such as schools, restaurants, airports, government buildings, and hospitals. We must educate smokers about the effect of smoking on their health as well as on the health of others.

**“We must take a position against allowing smoking in public places such as schools, restaurants, airports, government buildings, and hospitals.”**

We have enough information to limit smoking in public places for health reasons. I hope all chest physicians will review existing data and discuss cigarette smoking with their colleagues, their patients, their students, and the public. Make an active, not a passive, decision on your involvement in freeing society of cigarettes. Most chest physicians have been too quiet for the good of society.

**Written Testimony of**

**Peter Hanauer**

**President  
Americans for Nonsmokers' Rights  
2054 University Avenue, Suite 500  
Berkeley, CA 94704**

**Submitted to the  
Subcommittee on Health and the Environment  
Committee on Energy and Commerce  
United States House of Representatives**

**For Hearing on  
H.R. 4488 "Nonsmokers' Protection Act of 1986" and  
H.R. 4546 "Nonsmokers' Rights Act of 1986"**

**June 12, 1986**

Mr. Chairman and members of the Committee. My name is Peter Hanauer. I hold a law degree from Columbia University and I have been editing law books for more than twenty years. I have been involved in the nonsmokers' rights movement for twelve years and I am currently president of Americans for Nonsmokers' Rights. I want to thank you for the opportunity to testify in support of the nonsmokers' rights bills you are now considering.

During the last five years, Americans for Nonsmokers' Rights has helped to pass more than 100 laws at the state and local level in California to protect the right of nonsmokers to breathe clean air in public places and in places of employment. Approximately 50% of Californians now live in a city or county which regulates smoking in the workplace. State law also requires that all state agencies have a policy to protect the rights of nonsmoking employees.

Although California may have received the most attention on this issue, largely because of four ballot measures between 1978 and 1983, it is by no means the only place where nonsmokers' rights laws have been passed. In fact, in 1975--even before my nonsmokers rights' organization was formed--the state of Minnesota passed a comprehensive measure regulating smoking in all public places and workplaces. Currently, at least thirty-seven states regulate smoking to some extent in public places, and at least ten states regulate smoking in the workplace.

Thus, the bills before you will not thrust the federal government into new territory. To the contrary, these bills will merely bring the federal government in line with numerous state and local governments. The time has come for Congress to act to protect the health and comfort of the hundreds of thousands of federal employees as well as the millions of people who do business in or visit federally owned and operated buildings.

The legislation before you will be opposed by the tobacco industry, which for the last ten years has waged a cynical and reprehensible campaign throughout the country to prevent the enactment of such public health measures. They have spent and are continuing to spend tens of millions of dollars in elections and lobbying efforts. Yet in virtually every place that a nonsmokers' rights law is proposed it is being passed by near-unanimous votes. The reason is simple: the laws are overwhelmingly popular among both nonsmokers and smokers. In fact, the only opposition to these laws comes from the tobacco industry, which, as is evident from the public opinion polls, does not even represent the consumers of its product.

Recent surveys by three of the nation's most respected polling organizations demonstrate how much the public wants these laws. A 1983 Gallup Poll showed that 83% of the public believes that smoking should either be prohibited altogether or restricted in the workplace. Only 12% opposed any restrictions. A 1984 California Field Poll showed 83% in favor of workplace smoking restrictions and only 13% opposed. In 1985, a Lou Harris Poll, focusing on public places generally, found 80% in favor of smoking restrictions and only 15% opposed.

But probably the most important poll of all was conducted in Minnesota by the Minneapolis Star and Tribune in 1980, five years after the Minnesota Clean Indoor Air Act was passed. It showed 92% in favor of the law and a mere 5% opposed. Interestingly, a slightly higher percentage of smokers who smoked a pack of cigarettes or less per day supported the law than did nonsmokers. Actually, it is not surprising that most smokers favor smoking restrictions. There are three good reasons: 1) it helps them to quit smoking; 2) it reassures them they can smoke in designated smoking areas without being asked by others to stop; and 3) it affords them the means to avoid other people's smoke!

The overwhelming consensus about the desirability of smoking restrictions not only shows why the proposed legislation will be popular, but also why it will be easy to implement and enforce. It will essentially codify a change in social attitudes that has already occurred.

Once it is determined where smoking should and should not be permitted in a given facility, there are only three basic ingredients to a successful law:

- 1) The posting of signs clearly indicating the nonsmoking and smoking areas;
- 2) A clear statement that the right of nonsmokers to breathe clean air takes precedence over the desire to smoke; and
- 3) A reasonable enforcement mechanism.

Once the signs are posted (and, in places of employment, employees are informed of the regulations), these laws become essentially self-enforcing. In short, most people obey the signs just as most drivers obey stop signs, even though they know there is little likelihood of being given a ticket.

Of course, the tobacco industry argues that these laws are unnecessary--that "common courtesy" is sufficient. While that is a nice phrase, it is a totally impractical solution. That is so not because smokers lack courtesy, but rather because there is no basis for the exercise of courtesy without the establishment of ground rules as to where smoking is or is not permitted. To use the stop sign analogy again, most drivers are courteous and law-abiding, but if there were no stop signs, drivers would not know where they should stop. The "common courtesy" solution puts the burden on nonsmokers to continually ask others--often total strangers--to refrain from smoking. It is quite simply a recipe for confrontation between nonsmokers and smokers--the very thing the tobacco industry professes a

desire to avoid. Every mid-level manager in the Federal government should be supporting these bills as the best way to avoid the Solomon-like decisions they must try to make now when a confrontation between a nonsmoker and a smoker arises.

The universal experience with existing nonsmokers' rights legislation is that the costs of implementation and enforcement have been minimal. The one-time cost of posting signs is greatly overshadowed by long-term savings that will be realized in various areas such as increased productivity on the part of nonsmoking employees, reduced health care and insurance costs, reduced smoke and fire damage, and reduced maintenance expenses.

Since these laws have been self-enforcing, the associated costs have been negligible, with no need for added personnel. The San Francisco workplace ordinance provides an interesting illustration. When it was first proposed, it contained an appropriation to cover the cost of two additional health inspectors. But the mayor, who strongly supported the law, insisted that the appropriation be deleted and that the Health Department report back six months after the ordinance went into effect as to the impact of the law on its personnel needs. The Health Department found it could easily respond to all complaints with no additional personnel.

Despite the dire predictions of the tobacco industry--disruption of the economy, fistfights among employees, a decrease in tourism, and an exodus of small businesses--every nonsmokers' rights law in the country has been implemented and enforced without significant problems. To my knowledge, no such law has ever been weakened or repealed; however, many have been strengthened. The attached materials representing the views of numerous enforcement officials is ample testimony to the fact these laws work well.

When considering the arguments of the tobacco industry, I ask that you note the glaring inconsistency between the fact that the industry opposes

these laws so vigorously, and their contention that they are unenforceable.  
If no one obeyed the laws the industry would not have to worry about them.  
But it is precisely because they work so well that the industry works so  
hard to defeat them.



**Written Testimony of**

**STANTON A. GLANTZ, PH.D.**

**Associate Professor of Medicine  
University of California  
San Francisco, CA 94143**

**President  
Californians for Nonsmokers' Rights  
2054 University Avenue, Suite 500  
Berkeley, CA 94704**

**Submitted to the**

**Subcommittee on Civil Service, Post Office, and General Services  
Committee on Governmental Affairs  
United States Senate**

**For Hearing on S.1440  
The Non-Smokers Rights Act of 1985**

**September 30, 1985**

My name is Stanton A Glantz. I hold a PhD in Engineering and Economics from Stanford University and am now an Associate Professor of Medicine and Chairman of the Bioengineering Graduate Program at the University of California, San Francisco, where I conduct research into the mechanical function of the heart. I am also President of Californians for Nonsmokers' Rights, an organization that has helped to pass legislation protecting nonsmokers from the toxic chemicals in second-hand cigarette smoke in 44 California communities, encompassing approximately 9 million people.

Before discussing the specifics of our experience with legislation in California, I would like to speak briefly to two important general issues: the need for such legislation to protect the public health and the fact that the only organized opposition to such legislation comes from the tobacco industry.

First, there is absolutely no question that, as the National Academy of Sciences concluded in 1981, "involuntary exposure to tobacco smoke has adverse health effects and ought to be minimized or avoided where possible." There are over 600 papers in the medical literature on the effects of involuntary smoking supporting this conclusion.

As with primary smoking, the tobacco industry has tried to diffuse this overwhelming case by taking advantage of honest differences of opinion in the scientific community on the precise magnitude of the problem, misrepresenting the views of reputable scientists, or hiring professional quibblers to claim that "the case is not in." After every independent scientific body that addressed the question concluded that involuntary smoking represented a health hazard, the industry took the creative step of convening its own scientific panels -- in such scientifically impressive places as Geneva and Vienna -- in an effort to cast an aura of respectability on its position. Contrary to what the industry had hoped,

scientists at both meetings presented evidence that involuntary smoking was harmful. As a result the tobacco industry was reduced to quoting from press releases issued after the meetings by individuals. In contrast to statements made by the National Academy of Sciences and Surgeon General, these releases were not subject to any scientific quality control. As a result the only people that seem to take them seriously are the cigarette companies and their advertising agencies.

The simple fact is that one need not hold a PhD and own complex scientific equipment to know that second hand tobacco smoke is a serious form of indoor air pollution. Consider a room where people are smoking. Think about what the air looks like, what it smells like, what it tastes like. Consider the fact that your eyes or throat may burn, or that you may develop nausea, or a headache. If you went outdoors and the air was that polluted, you would be outraged. And you would be right.

That is why we have passed legislation cleaning up the outdoor air, and why this bill is necessary to help clean up the air indoors, where most Federal workers spend most of their time.

My involvement in this issue dates to 1978 when I worked with others in an unsuccessful attempt to pass, by initiative, the California Clean Indoor Air Act which would have created nonsmoking sections in the workplace and public places. Before the campaign started, every poll conducted (including those done for the Tobacco Institute) showed the initiative passing by a 3-1 majority. The cigarette companies spent \$6,500,000 on a massive advertising campaign and defeated the law. The tobacco industry represented to only organized opposition we faced.

The same thing happened again in 1980.

In 1981, we began working at the state and local level to pass

nonsmoker protection ordinances. We believed that, since the tobacco industry had no real support, informed and organized local constituents could overcome the pressure of lobbyists, lawyers and campaign contributions.

This strategy has proven successful. As of this date, every California community that has considered a law protecting nonsmoker in the workplace has enacted it, despite vigorous, well-financed opposition from the tobacco industry.

The industry's failure to stop us and other like-minded groups around the country has led them to another strategy: they are attempting to shift the field of play back to the ballot box where they hope they can buy elections with slick advertising campaigns. Fortunately, the American public has not been tricked by their efforts. In addition to the industry's highly-publicized \$1.3 million effort to get the San Francisco Workplace Smoking Ordinance repealed two years ago, their front groups have been rejected by the voters in Arizona and Colorado. This willingness of the populace to stand up to the industry attests to the importance and popularity of protecting nonsmokers from second hand smoke.

In fact, our success is not surprising, given that every poll done on the subject (including those done for the Tobacco Institute) have shown a majority -- including a majority of smokers -- in favor of legislation to protect nonsmokers.

This overwhelming consensus about the desirability of protecting nonsmokers is why legislation such as that before you is easy to impliment and enforce. It essentially codifies a change in social attitudes that has already occurred.

Given this broad consensus, why do we need laws? Why can't we depend on "common courtesy" as the ciagarette companies suggest? Because "common

courtesy" is a recipe for individual confrontation. Under the current situation, individual nonsmokers are forced to confront individual smokers to ask that they smoke elsewhere. Most people are simply not that aggressive.

Furthermore, the ubiquity of cigarette advertising and second hand cigarette smoke in the air, nonsmokers feel very isolated and are often afraid to speak up. The presence of a simple "No Smoking" sign dramatically changes this situation. With the sign available, nonsmokers feel comfortable in asking people not to smoke.

Let me give you an example. Several years ago I was sitting in the Minneapolis airport enjoying the benefits of the Minnesota Clean Indoor Air Act which was passed in 1987. A man then sat down next to me and began to take out a cigarette. I asked him not to smoke. He initially objected to my intrusion, until I pointed out that we were in a nonsmoking area. He then apologized and put the cigarette away. Surprisingly enough, he did not move to the smoking section. He simply smoked one less cigarette.

That was one less cigarette that a tobacco company sold. To understand the impact of that simple act consider this: If every smoker in America smoked just one less cigarette a day due to changing social attitudes or legal restrictions, there would be 22 billion fewer cigarettes sold each year.

Given these stakes, it is not surprising that the tobacco companies are willing to spend a few million dollars in their unsuccessful attempts to convince Americans that smokers should be free to pollute the indoor air without restriction.

Despite dire predictions of earthquakes in San Francisco and fires in Los Angeles, California, every ordinance I know of has gone into force

smoothly.

No city or county that has ever passed an ordinance has weakened or repealed it.

While it is important that there be strong enforcement provisions in the law to ensure that people take it seriously, there has never, to my knowledge, been the need to fine anyone. Enforcement has taken the form of education and negotiation, with legal sanctions playing a quiet but secondary role to back up the negotiations.

In sum, there are four simple principles that lead to successful, trouble-free nonsmokers' rights legislation:

- (1) There need to be signs posted in the nonsmoking areas.
- (2) There needs to be the capacity for strong enforcement; ironically, the presence of sanctions avoids the need for using them.
- (3) There needs to be a clear statement that the right to breathe clean air takes precedence over the choice to smoke.

The existing bill meets the first two criteria; to meet the third criterion, I suggest that the following language be added at page 3 line 9 after "government buildings": "provided, however, that in any dispute arising under such rules and regulations, the needs of nonsmokers shall be given precedence;"

I have no doubt that passage of the legislation before you will quickly, simply and inexpensively clear the air for Federal employees. It will also help encourage other public and private employers to follow your lead and produce a safer and healthier environment for all of us.

Thank you.

**Attachments:**

"San Francisco Anti-Smoking Law a Success", Wall Street Journal, August 15, 1984

Letter from Surgeon General Koop regarding the health effects of involuntary smoking

Letters from city, county, and state officials regarding ease of enforcement of various ordinances:

John Lockwood, Assistant City Manager, San Diego

Roger Hedgecock, Mayor, San Diego

George Story, Director, Citizens Assistance & Information, San Diego

James Forde, Director, Department of Health Services, San Diego County

Bruce Tsutsi, Inspector, Department of Public Health, San Francisco

Rita Hardin, Director, Neighborhood Preservation, San Jose

C. B. Schneider, Chief, Section of Environmental Field Services, Minnesota department of Health

Letter from Art Pick, Executive Vice President, Greater Riverside Chambers of Commerce, endorsing a proposed ordinance (which passed)

# NEWS from

AMERICAN  LUNG ASSOCIATION  
The Christmas Seal People®

1740 Broadway, New York, N.Y. 10019 (212) 315-8700

EMBARGOED FOR RELEASE:

6:30 p.m. (EST) THURSDAY, DEC. 5, 1985

CONTACT: Michele Kling

Dec. 3-4 (212) 315-8836

Dec. 6-7 (305) 634-7711

OR

Elaine Chapnick

(212) 315-8740

## AMERICANS WANT SMOKE-FREE AIR AT WORK

COLORADO SPRINGS, COLO., December 5, 1985--For the first time, there is documentation that the vast majority of Americans want smoking regulations at the workplace. Eighty-seven percent of Americans--smokers and nonsmokers--now believe companies should either ban smoking totally at work or restrict it to designated areas, according to a new national survey released today by the American Lung Association--the Christmas Seal People®.

The same survey also showed that fully 75 percent of Americans believe that smokers should not light up in the presence of nonsmokers. This figure is up 6 percentage points from the 69 percent recorded in the Lung Association's original 1983 survey of attitudes toward smoking. And 94 percent of Americans now believe smoking is hazardous to health, as compared with 92 percent in 1983.

Despite tobacco industry claims that there is no need for smoking regulations at the workplace, the survey, which was conducted by the Gallup Organization for the Lung Association, found that 80 percent of current smokers, 92 percent of nonsmokers, and 89 percent of former smokers feel companies should have policies designating smoking and nonsmoking areas in the workplace or totally banning smoking at work.

- more -



Americans Want Smoke-Free Air at Work--2

"More and more companies around the U.S. are instituting smoking restrictions at the office in response to the needs and wishes of the employees," said ALA Managing Director James A. Swomley. "This survey documents what American business has been demonstrating--that Americans now understand the health hazards of smoking go beyond the active smoker to the involuntary smoker."

Swomley said the Lung Association's survey reflects "a new assertiveness among American employees who can't be fooled by the cigarette industry's claim that smoking is merely an issue of courtesy and not a health issue."

"But," Swomley said, "this attitude is not new to those of us in public health education. Our survey shows that 62 percent of America's current smokers agree that they should not smoke in the presence of nonsmokers. This represents an increase of 7 percentage points in just two years.

"We are dealing with a serious health issue here," Swomley added. "When both smokers and nonsmokers alike agree that the air should be free of smoke, they're worried about their health and health of those around them."

Swomley said the time has come to address the addictive nature of tobacco. The U.S. Public Health Service has called smoking "the most widespread example of drug dependence in this country," he noted. U.S. Surgeon General C. Everett Koop, M.D., earlier this week said, "Seventy-eight percent of the nation's 53 million smokers wish they could quit but can't...because they're addicted."

The Lung Association survey, carried out through personal interview with a national sample of adults over age 18, asked 1,540 men and women their opinions about smoking. Other data from this survey showed:

- Among those who said companies should have separate areas for smoking and nonsmoking, 76 percent are current smokers and 80 percent are former smokers.

- more -

**Americans Want Smoke-Free Air at Work--3**

- 62 percent of the respondents felt smokers should refrain from smoking in a public place.
- 32 percent felt there should be a total ban on cigarette advertising.
- Another 36 percent believed there should be curbs on some types of advertising.

The American Lung Association, dubbed in 1981 by the Tobacco Institute as its "No. 1 adversary," is the oldest nationwide voluntary health agency in the U.S. and was one of the first health organizations to assume major public education activities on behalf of nonsmokers' rights and the health effects of involuntary smoking.

# # #

EDITOR'S NOTE: SEE ATTACHED STATISTICS AND ILLUSTRATIONS.

12/85  
/dsp

**Merit  
Systems  
Protection  
Board**

**NOTICE**

No: 86-46

Date: April 29, 1986

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BUILDINGS AND SPACE MANAGEMENT (1510)

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**BAN ON SMOKING AT MSPB**

Smokers slowly burn it; non-smokers, some of them, slowly burn because of it. Not only people but machines as well, most notably our omnipresent H-P computers, are affected adversely by the smoke and ash associated with cigarettes and the like. As our offices become increasingly smaller, the problem of smoking looms ever larger. The conclusion is inescapable that the efficiency of the Board's operations is compromised by the contaminants associated with smoking. It's time to clear the air.

Effective May 15, 1986, the Board will join the growing ranks of public and private sector offices that prohibit smoking, in the regions and in headquarters; in private offices as well as open space; in meeting rooms, hearing rooms, rest rooms, and corridors. All of us<sup>1/</sup> and all our visitors, too.

In an effort to assist employees in the transition to a smoke-free environment, for the next ninety days a reasonable number of short breaks will be permitted away from the premises for those unable to cope otherwise. Stairwells or, at headquarters, for example, the terrace canteen and cafeteria, may be considered away from the premises.

Our commitment to a smoke-free environment is now the policy of the Board. I realize that this will cause, at least temporarily, some inconvenience to some of you. However,

1/ Given our statutory obligations to complete the bargaining process with the Association, this directive is not presently effective as to bargaining unit personnel. Members of the unit are urged, however, as a matter of courtesy to their fellow employees, to limit smoking, voluntarily and without fear of penalty, to their private offices or an appropriately ventilated area away from the HP equipment.

(over

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Distribution: ALL EMPLOYEES

Initiated by: BC

your support is greatly appreciated. The MSPB Recreation Association is looking into ways of providing assistance to those who desire to break the habit. Watch for future announcements.

Failure to abide by the Board's "No Smoking" policy will be dealt with in the same manner as any other violation of an administrative directive or rule.

A handwritten signature in cursive script that reads "Maria L. Johnson". The signature is written in black ink and is positioned above the typed name.

Maria L. Johnson  
Acting Chairman



# NEWS RELEASE

U.S. MERIT SYSTEMS PROTECTION BOARD  
Public Information and Media Services Division  
Washington, D.C. 20419  
(202) 653-7124

Contact: Paul Trayers  
(202) 653-7175

May 13, 1986  
Immediate Release

## MSPB BANS SMOKING

In a recent notice sent to its employees, the U.S. Merit Systems Protection Board announced that, as of the 15th of May, it will ban smoking throughout the agency. The notice, signed by Acting Board Chairman Maria L. Johnson, cited increasingly smaller office space and adverse effects to both employees and computer equipment as grounds for the ban. Stating, "It's time to clear the air," the notice said:

Effective May 15, 1986, the Board will join the growing ranks of public and private sector offices that prohibit smoking, in the regions and in headquarters; in private offices as well as open space; in meeting rooms, hearing rooms, rest rooms, and corridors.

Timed in conjunction with a health and fitness drive at the Board commemorating National Physical Fitness and Sports Month, the announcement went on to say that there will be a ninety-day grace period during which "a reasonable number of short breaks will be permitted away from the premises, for [smokers] unable to cope otherwise."

In addition, an earlier notice on the health and fitness program announced:

...the [Board's] Recreation Association will offer the American Cancer Society FRESHSTART program, designed to help smokers stop smoking. The program consists of four one-hour, small group sessions. This program is offered without charge and administrative leave will be authorized for those who participate.

"Our commitment to a smoke-free environment," stated Acting Chairman Johnson, "is now the policy of the Board."



GSA #1111

May 22, 1986

## News Release

Contact: Joseph M. Slye 202/566-0705

### GSA's Golden Previews New Smoking Rules For Federal Buildings

SEATTLE, Wash. (May 22) — The head of the U.S. General Services Administration (GSA) announced here today proposed regulations that would ban government employees and the public from smoking -- except at designated smoking areas -- in the 6,800 buildings nationwide managed by GSA.

Administrator Terence C. Golden previewed the stringent new regulations in keynote remarks at the opening of a two-day Regional Conference on Public Employee Fitness and Health sponsored by the President's Council on Physical Fitness and Sports. The theme for his address was the "total wellness" of government workers.

Golden said the new regulations, which were scheduled for publication today in the Federal Register for a 60-day comment period, probably will not take effect until this fall. The smoking ban will include general office space, lobbies, corridors, conference rooms, classrooms, libraries, elevators and rest rooms. Designated smoking areas will be established at cafeterias and vending facilities. Nothing in the regulations precludes an agency from setting more stringent guidelines.

He told the physical fitness program managers that his smoking ban regulation is one of several initiatives designed to promote the "total wellness" of federal employees, including:

- Safety improvements in the workplace, including the removal of asbestos, PCB transformers and other hazardous materials;

--MORE--

U.S. General Services Administration, Washington, DC 20405 (202) 566-1231

attractive environment as an incentive for increased productivity;

- Strengthened physical security in public areas and at the workplace for government workers in federal buildings;
- Clearing the way for federal agencies to establish and sponsor physical fitness facilities for government workers;
- Making it possible for day care centers to be established at GSA managed buildings for sponsors to help meet the needs of working parents.

Golden said "the official regulations I have proposed for federal buildings are a positive step toward the 'total wellness' of federal employees. Hand-in-hand with other initiatives to improve the quality of the federal workplace, the federal workforce can be healthier, happier and more efficient."

He said his main concern is for the health of the federal worker, adding "smoking has begun to infringe on the health interests of nonsmokers in the workplace. No longer is it the right of the individual to smoke without regard for the health concerns of those who work in the same area."

Citing cigarette smoking as the cause of some 340,000 premature deaths annually, Golden said in 1984 the direct medical costs from smoking-related disease and death totalled \$23,300,000,000 with indirect costs from smoke-related illnesses set at \$9,300,000,000.

# # #

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Washington, DC 20405

GENERAL SERVICES ADMINISTRATION  
PUBLIC BUILDINGS SERVICE

(41 CFR Part 101-20)

SMOKING REGULATIONS

AGENCY: General Services Administration.

ACTION: Proposed rule.

SUMMARY: This regulation provides for revised smoking regulations in buildings controlled by GSA. It has become necessary to regulate smoking in certain areas of Federal buildings because smoke in a confined area may be irritating and annoying to non-smokers. In addition, the Office of the Surgeon General has indicated that current scientific evidence suggests that exposure to ambient tobacco smoke can be hazardous to non-smokers and may create a potential hazard to those suffering from heart and respiratory diseases or allergies. GSA also recognizes the rights of individuals to smoke in such buildings provided such action does not cause discomfort or unreasonable annoyance to non-smokers or infringe upon their rights. The intent of this regulation is to provide a reasonably smoke-free environment for those working and visiting GSA-controlled buildings.

DATE: Comments must be received on or before: (60 days from the date of publication in the Federal Register).

ADDRESS: Written comments should be sent to the General Services Administration (PPS), Washington, DC 20405.



FOR FURTHER INFORMATION CONTACT: Mr. James A. Marsden, Acting Director, Facility Management Division, (202-566-1563).

SUPPLEMENTARY INFORMATION: The General Services Administration has determined that this rule is not a major rule for the purposes of E. O. 12291 of February 17, 1981, because it is not likely to result in an annual effect on the economy of \$100 million or more; a major increase in costs to consumers or others; or significant adverse effects. Therefore, a Regulatory Impact Analysis has not been prepared. GSA has based all administrative decisions underlying this rule on adequate information concerning the need for, and the consequence of, this rule; has determined that the potential benefits to society from this rule outweigh the potential costs and has maximized the net benefits; and has chosen the alternative approach involving the least net cost to society.

GSA proposes to amend Part 101-20 as follows:

PART 101-20-- MANAGEMENT OF BUILDINGS AND GROUNDS

1. The authority citation for Part 101-20 continues to read as follows:

AUTHORITY: Sec. 205(c), 63 Stat: 390; 40 U.S.C. 486(c)

SUBPART 101-20.1 BUILDING OPERATIONS, MAINTENANCE, PROTECTION, AND ALTERATIONS

2. SECTION 101-20.109-10 is revised to read as follows:

101-20.109-10 Regulation of smoking.

Regulations for controlling smoking in GSA-controlled buildings and facilities are set forth below. Agencies are encouraged to

develop additional guidelines for internal use and for action when violations of these regulations occur. Nothing in these regulations precludes an agency from establishing more stringent guidelines. For purposes of these regulations, general office space is defined as space occupied by personnel performing their daily work functions; this includes, but is not limited to: ADP areas, mail rooms, file rooms, duplicating areas, court and jury rooms, office space, etc.

(a) Smoking is prohibited in the following areas, except as designated pursuant to paragraph (b) (1) below.

(1) General office space.

(2) Auditoriums, classrooms, and conference rooms.

(3) Elevators. "No smoking" signs shall be posted in elevators, adequate receptacles shall be placed outside the entrances.

(4) Corridors, lobbies and restrooms.

(5) Medical care facilities such as medical clinics and health units.

(6) Libraries.

(7) Hazardous areas. Each agency shall post and enforce "no smoking" rules in any location under its jurisdiction which involves flammable liquids, flammable gases, or flammable vapors, or in all other locations where there is a collection of readily ignitable, combustible materials.

(b) Smoking is permitted in the following designated "smoking areas:

(1) Agency heads will be responsible for establishment of designated "smoking" areas, in addition to monitoring and controlling these areas. Agencies are responsible for ensuring that designated "smoking" areas are identified by appropriate signs. Agencies in multi-tenant buildings are encouraged to work together to identify these designated "smoking" areas.

(2) "Smoking" areas shall be established in cafeterias, including Randolph-Sheppard vending facilities and automatic vending areas. These areas shall be designated as "smoking" areas by each buildings manager, in collaboration with the heads of the occupant agencies. The areas designated shall be based upon an estimate of the number of smoking and non-smoking patrons served. This may be adjusted on the basis of local experience. The designated "smoking" areas shall be identified by appropriate signs.

(3) A private office may be declared a "smoking" area by the agency.

(c) Agencies are responsible for providing adequate ash trays or receptacles in the designated "smoking" areas.

(d) Suitable, uniform signs reading "No Smoking Except in Designated Areas" shall be placed on or near entrance doors of buildings subject to these regulations. It should not be necessary to display a sign in every room of such buildings.

(e) An agency is not required by this regulation to make any expenditures for structural changes to accommodate the preferences of non-smoking or smoking employees.

Dated:

WILLIAM F. SULLIVAN  
Commissioner,  
Public Buildings Service

99TH CONGRESS  
1ST SESSION

# S. 1440

To restrict smoking to designated areas in all United States Government buildings.

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## IN THE SENATE OF THE UNITED STATES

JULY 16, 1985

Mr. STEVENS (for himself, Mr. GOLDWATER, Mr. MURKOWSKI, Mr. HATCH, Mr. PROXMIRE, and Mr. MATSUNAGA) introduced the following bill; which was read twice and referred to the Committee on Governmental Affairs

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## A BILL

To restrict smoking to designated areas in all United States Government buildings.

1       *Be it enacted by the Senate and House of Representa-*  
2       *tives of the United States of America in Congress assembled,*  
3       That this Act may be cited as the "Non-Smokers Rights Act  
4       of 1985".

5

### FINDINGS

6

SEC. 2. The Congress finds that—

7

(1) numerous studies have shown second-hand

8

smoke to be a significant health hazard;

1 (2) recent court decisions recognize an emerging  
2 right of employees to work in a smoke-free environ-  
3 ment; and

4 (3) smoking results in increased costs to employ-  
5 ers and the public in the form of more frequent absen-  
6 teeism by employees who smoke and higher costs for  
7 health insurance, fire insurance, life insurance, and  
8 workers' compensation.

9 UNITED STATES GOVERNMENT BUILDINGS

10 SEC. 3. (a) Within 180 days after the date of enactment  
11 of this Act and as provided in subsection (b)—

12 (1) the Administrator of the General Services Ad-  
13 ministration shall prescribe and implement such reason-  
14 able rules and regulations as may be necessary to des-  
15 ignate smoking areas in any building under the juris-  
16 diction and control of a department or agency of the  
17 United States;

18 (2) the Committee on Rules and Administration of  
19 the Senate and the Committee on House Administra-  
20 tion of the House of Representatives shall prescribe  
21 and implement such reasonable rules and regulations as  
22 may be necessary to designate smoking areas in any  
23 building under the jurisdiction and control of the Con-  
24 gress; and

25 (3) the Administrator of the Administrative Office  
26 of the United States Courts shall prescribe and imple-

1       ment such reasonable rules and regulations as may be  
2       necessary to designate smoking areas in any building  
3       under the jurisdiction and control of the judicial branch  
4       of Government.

5       (b)(1) Rules and regulations for United States Govern-  
6       ment buildings prescribed pursuant to subsection (a) shall—

7           (A) make reasonable accommodations for the  
8       needs of the smokers and nonsmokers who use the  
9       Government buildings; and

10          (B) conspicuously display signs in each building  
11       that specify the portions of the building in which smok-  
12       ing is allowed by law and in which smoking is prohibit-  
13       ed by law.

14       (2) A sign required by paragraph (1)(B) shall be at least  
15       18 inches wide and 6 inches high, with lettering at least 1.25  
16       inches high.

17       (c)(1) Whoever smokes in an area of a United States  
18       Government building not designated as a smoking area pur-  
19       suant to this section shall be subject to a civil fine of not less  
20       than \$50 nor more than \$500.

21       (2) This subsection shall be effective 180 days after the  
22       date of enactment of this Act.

○

Calendar No. 483

99TH CONGRESS  
1ST SESSION

**S. 1937**

[Report No. 99-220]

To restrict smoking to designated areas in all United States Government buildings.

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IN THE SENATE OF THE UNITED STATES

DECEMBER 12 (legislative day, DECEMBER 9), 1985

Mr. ROTH, from the Committee on Governmental Affairs, reported the following original bill; which was read twice and placed on the calendar

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**A BILL**

To restrict smoking to designated areas in all United States Government buildings.

1 *Be it enacted by the Senate and House of Representa-*  
2 *tives of the United States of America in Congress assembled,*  
3 That this Act may be cited as the "Non-Smokers Rights Act  
4 of 1985".

5 **FINDINGS**

6 **SEC. 2.** The Congress finds that—

7 (1) numerous studies have shown second-hand  
8 smoke to be a significant health hazard;



1           (2) recent court decisions recognize an emerging  
2           right of employees to work in a smoke-free environ-  
3           ment; and

4           (3) smoking results in increased costs to employ-  
5           ers and the public in the form of more frequent absen-  
6           teeism by employees who smoke and higher costs for  
7           health insurance, fire insurance, life insurance, and  
8           workers' compensation.

9           **DESIGNATION OF SMOKING AREAS IN ALL UNITED STATES**

10                           **GOVERNMENT BUILDINGS**

11           **SEC. 3.** Within 180 days after the date of enactment of  
12           this Act, except as provided in section 4(b), the United States  
13           Government shall establish designated smoking areas in all  
14           Government buildings as provided in sections 4, 5, and 6.

15                           **EXECUTIVE BRANCH**

16           **SEC. 4.** (a)(1) The Administrator of General Services  
17           shall prescribe and provide for implementation of such rea-  
18           sonable rules and regulations as may be necessary to desig-  
19           nate smoking areas in public buildings as defined in section  
20           13 of the Public Buildings Act of 1959 and any other build-  
21           ings or portions thereof under the custody or control of the  
22           Administrator, including leased space.

23           (2) The head of the agency or department with jurisdic-  
24           tion over the building in control of such agency or depart-  
25           ment shall be responsible for implementing regulations pre-

1 scribed by the Administrator of General Services pursuant to  
2 paragraph (1).

3 (b)(1) Not later than 180 days after the Administrator of  
4 General Services prescribes rules and regulations under sub-  
5 section (a), the head of a department or agency of the United  
6 States, including Postmaster General of the Postal Service,  
7 with jurisdiction or control over any building, or portion of a  
8 building, not described in subsection (a), shall prescribe and  
9 provide for implementation of such reasonable rules and regu-  
10 lations as may be necessary to designate smoking areas in  
11 such building or portion of a building within such department  
12 or agency head's jurisdiction or control, including leased  
13 space.

14 (2)(A) In prescribing rules and regulations under para-  
15 graph (1) and except as provided in subparagraph (B), the  
16 head of the department or agency shall adopt policies that  
17 are consistent with the policies reflected in the rules and reg-  
18 ulations prescribed by the Administrator of General Services  
19 under subsection (a).

20 (B) The head of the department or agency may adopt  
21 rules and regulations inconsistent with those prescribed by  
22 the Administrator of Government Services to the extent that  
23 the head determines that the adoption of the policies reflected  
24 in such rules and regulations would be inconsistent with the  
25 proper execution of the statutory missions of such department

1 or agency. If the head adopts inconsistent rules and regula-  
2 tions, he shall specify the reasons for adopting such inconsist-  
3 ent rules and regulations in a written determination submit-  
4 ted to the Administrator and the Surgeon General and shall  
5 include the written determination and the inconsistent rules  
6 and regulations in the rules or regulations of such agency or  
7 department.

8

#### LEGISLATIVE BRANCH

9 . SEC. 5. The Committee on Rules and Administration of  
10 the Senate and the Committee on House Administration of  
11 the House of Representatives shall prescribe and implement  
12 such reasonable rules and regulations as may be necessary to  
13 designate smoking areas in any building or portion thereof  
14 under the jurisdiction or control of the Congress, including  
15 leased space.

16

#### JUDICIAL BRANCH

17 SEC. 6. The Administrator of the Administrative Office  
18 of the United States Courts shall prescribe and implement  
19 such reasonable rules and regulations as may be necessary to  
20 designate smoking areas in any building or portion thereof  
21 under the jurisdiction or control of the judicial branch of Gov-  
22 ernment, including leased space.

23

#### RULES AND REGULATIONS

24 SEC. 7. (a) Rules and regulations for United States  
25 Government buildings prescribed pursuant to this Act shall—

1 (1) be developed in consultation with the Surgeon  
2 General;

3 (2) be implemented after consultation with the ex-  
4 clusive representatives of employees in appropriate  
5 units in an affected agency;

6 (3) make reasonable accommodations for the needs  
7 of the smokers and nonsmokers who use the Govern-  
8 ment buildings;

9 (4) provide for the conspicuous display of signs in  
10 each building that specify the portions of the building  
11 in which smoking is allowed pursuant to law and in  
12 which smoking is prohibited pursuant to law;

13 (5) provide for the effective enforcement of the  
14 prohibition on smoking in areas where smoking is pro-  
15 hibited; and

16 (6) be published in the Federal Register.

17 (b) In implementing rules and regulations under this  
18 Act, provision shall be made for designated smoking areas for  
19 smokers within existing facilities.

20 (c) No rule or regulation prescribed pursuant to this Act  
21 shall supersede a rule or regulation providing more stringent  
22 restrictions on smoking.

23 **EFFECTIVE DATE**

24 **SEC. 8.** This Act shall be effective 180 days after the  
25 date of enactment of this Act.

99TH CONGRESS  
2D SESSION

# H. R. 4488

To restrict smoking to designated areas in all buildings or building sections  
occupied by the United States Government.

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## IN THE HOUSE OF REPRESENTATIVES

MARCH 21, 1986

Mr. SCHEUER introduced the following bill; which was referred to the Committee  
on Energy and Commerce

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## A BILL

To restrict smoking to designated areas in all buildings or  
building sections occupied by the United States Government.

1 *Be it enacted by the Senate and House of Representa-*  
2 *tives of the United States of America in Congress assembled,*

3 SECTION 1. SHORT TITLE.

4 This Act may be cited as the "Non-Smokers' Protection  
5 Act of 1986".

6 SEC. 2. FINDINGS.

7 The Congress finds the following—

8 (1) Numerous studies have found that tobacco  
9 smoke is a major contributor to indoor air pollution.

1           (2) Studies have shown involuntary smoking to be  
2           a significant health hazard for several populations, in-  
3           cluding elderly people, individuals with cardiovascular  
4           disease, and individuals with impaired respiratory func-  
5           tion, including asthmatics and those with obstructive  
6           airway disease.

7           (3) Health hazards induced by involuntary smok-  
8           ing include lung cancer, respiratory infection, decreased  
9           exercise tolerance, decreased respiratory functions,  
10          bronchoconstriction, and bronchospasm.

11          (4) Nonsmokers with allergies, respiratory dis-  
12          eases and those who suffer other ill effects of breathing  
13          secondhand smoke may experience a loss of job  
14          productivity.

15          (5) Recent court decisions recognize an emerging  
16          right of employees to work in a smoke-free  
17          environment.

18          (6) Smoking results in increased costs to employ-  
19          ers and the public in the form of more frequent absen-  
20          teeism by employees who smoke and higher costs for  
21          health insurance, fire insurance, life insurance, and  
22          workers' compensation.

1 **SEC. 3. RIGHTS OF NON-SMOKERS IN FEDERAL GOVERNMENT**  
2 **BUILDINGS.**

3 (a) **ESTABLISHMENT OF NO-SMOKING POLICY.**—It is  
4 hereby established to be the policy of the United States Gov-  
5 ernment that it should provide an environment free from to-  
6 bacco smoke to the maximum extent practicable in the build-  
7 ings occupied by the Government.

8 (b) **REGULATIONS.**—

9 (1) The Secretary of Health and Human Services  
10 (hereinafter referred to as the “Secretary”), in consul-  
11 tation with the Surgeon General, shall promulgate reg-  
12 ulations to carry out such policy.

13 (2)(a) Such regulations shall, at a minimum, pro-  
14 vide that smoking shall not be permitted in buildings or  
15 in building sections occupied by the United States  
16 Government.

17 (b) **EXCEPTIONS.**—The Secretary may, by regulation,  
18 exempt certain limited areas of Government-occupied build-  
19 ings from such restriction on smoking if he or she finds that  
20 such restriction would cause undue hardship to smokers and  
21 that the needs of smokers could be reasonably accommodated  
22 without risk to the health and safety of nonsmokers occupy-  
23 ing the building. In any dispute arising under the smoking  
24 policy, the rights of the nonsmoker shall be given precedence.

25 (c) **SIGNS.**—Signs shall be posted specifying that no  
26 smoking is permitted anywhere in the building except where

1 posted signs indicate that smoking is permitted. Such signs  
2 located at each entrance shall indicate the location of desig-  
3 nated smoking areas in the building.

4 (d) **PERIOD FOR PROMULGATING RULES.**—The Secre-  
5 tary shall promulgate regulations under subsection (b) within  
6 180 days after the date of enactment of this Act. These regu-  
7 lations shall be published in the Federal Register.

8 **SEC. 4. SOLICITING COMMENTS FROM LABOR ORGANIZA-**  
9 **TIONS.**

10 Before promulgating regulations for a building or build-  
11 ing section under section 3(b), the Secretary shall solicit and  
12 consider comments regarding the designation of smoking  
13 areas within such building or building section from any labor  
14 organization representing employees working in such building  
15 or building section. Such comments shall suggest the size,  
16 number, and location of smoking areas that would be most  
17 mutually convenient for the nonsmokers and smokers using  
18 such building or building section.

19 **SEC. 5. ENFORCEMENT.**

20 The Secretary shall provide for the effective enforce-  
21 ment of the prohibition on smoking in areas where smoking is  
22 prohibited.

23 **SEC. 6. LIMITATIONS.**

24 (a) **EFFECT ON EXISTING REGULATIONS.**—No regula-  
25 tion promulgated under section 3(b) shall repeal or otherwise



5

1 affect the application of any existing regulation which curbs  
2 smoking more stringently than the regulations promulgated  
3 under section 3(b).

4 (b) POWER TO PROMULGATE MORE STRINGENT REG-  
5 ULATIONS.—Nothing in section 3(b) shall prevent the pro-  
6 mulgation of regulations which curb smoking more strin-  
7 gently than the regulations promulgated under section 3(b).

○

99TH CONGRESS  
2D SESSION

# H. R. 4546

To restrict smoking to designated areas in all buildings or building sections occupied by the United States Government.

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## IN THE HOUSE OF REPRESENTATIVES

APRIL 9, 1986

Mr. RITTER (for himself, Mr. BEREUTER, Mr. BOEHLERT, Mr. CHANDLER, Mrs. COLLINS, Mr. NIELSON of Utah, Mr. OBERSTAR, Mrs. SCHNEIDER, Mr. STARK, Mr. SYNAR, Mr. WAXMAN, and Mr. WHITTAKER) introduced the following bill; which was referred to the Committee on Energy and Commerce

---

## A BILL

To restrict smoking to designated areas in all buildings or building sections occupied by the United States Government.

1 *Be it enacted by the Senate and House of Representa-*  
2 *tives of the United States of America in Congress assembled,*

3 **SECTION 1. SHORT TITLE.**

4 This Act may be cited as the "Non-Smokers' Rights  
5 Act of 1986".

6 **SEC. 2. FINDINGS.**

7 The Congress finds the following:

8 (1) The presence of tobacco smoke in offices with  
9 typical occupancy rates and normal ventilation can

1 expose workers to air pollution levels which violate  
2 both the national primary ambient air quality standards  
3 for particulate matter and the national secondary ambi-  
4 ent air quality standards for particulate matter promul-  
5 gated by the Administrator of the Environmental Pro-  
6 tection Agency (40 C.F.R. 50.6 et. seq.). To the gen-  
7 eral population, tobacco smoke is the greatest source of  
8 this harmful type of pollution.

9 (2) Numerous studies have shown that exposure  
10 to indoor air polluted by tobacco smoke is a significant  
11 health hazard for non-smokers.

12 (3) Recent court decisions recognize an emerging  
13 right of employees to work in a smoke-free environ-  
14 ment.

15 (4) Studies show that smoking results in increased  
16 costs to employers and the public in the form of more  
17 frequent absenteeism by employees who smoke and  
18 higher costs for health insurance, life insurance, and  
19 worker's compensation.

20 **SEC. 3. DESIGNATION OF SMOKING AREAS.**

21 (a) **PROMULGATING REGULATIONS.**—The Secretary of  
22 Health and Human Services (hereinafter in this Act referred  
23 to as the "Secretary"), in consultation with the Surgeon  
24 General, shall promulgate regulations designating the exclu-  
25 sive areas in which smoking shall be allowed within all build-

1 ings or building sections occupied by the United States Gov-  
2 ernment.

3 (b) PERIOD FOR PROMULGATING RULES.—The Secre-  
4 tary shall promulgate regulations under subsection (a) within  
5 180 days after the date of enactment of this Act.

6 (c) SIGNS.—Regulations promulgated under subsection  
7 (a) shall require the conspicuous display of signs as follows:

8 (1) Signs shall be displayed, at each entrance of  
9 each building or building section subject to such regu-  
10 lations, which specify that smoking is allowed within  
11 such building or building section only in posted smok-  
12 ing areas.

13 (2) Signs shall be displayed, in each area desig-  
14 nated as a smoking area under such regulations, which  
15 specify that smoking is permitted in such area.

16 **SEC. 4. SOLICITING COMMENTS FROM LABOR ORGANIZA-**  
17 **TIONS AND LOCAL HEALTH ORGANIZATIONS.**

18 Before promulgating regulations for a building or build-  
19 ing section under section 3(a), the Secretary shall solicit and  
20 consider comments regarding the designation of smoking  
21 areas within such building or building section from public  
22 health organizations serving the area in which such building  
23 is located and from any labor organization representing em-  
24 ployees working in such building or building section. Such  
25 comments shall suggest the size, number, and location of

1 smoking areas that would be most mutually convenient for  
2 the smokers and non-smokers using such building or building  
3 section.

4 **SEC. 5. ENFORCEMENT.**

5 The Secretary shall provide for the enforcement of the  
6 regulations promulgated under section 3(a).

7 **SEC. 6. LIMITATIONS.**

8 (a) **EFFECT ON EXISTING REGULATIONS.**—No regula-  
9 tion promulgated under section 3(a) shall repeal or otherwise  
10 affect the application of any existing regulation which curbs  
11 smoking more stringently than the regulations promulgated  
12 under section 3(a).

13 (b) **POWER TO PROMULGATE MORE STRINGENT REG-**  
14 **ULATIONS.**—Nothing in section 3(a) shall prevent the pro-  
15 mulgation of regulations which curb smoking more stringent-  
16 ly than the regulations promulgated under section 3(a).

○