COUNCIL OF THE CITY OF PHILADELPHIA

PUBLIC HEARING BEFORE COUNCIL COMMITTEE ON

PUBLIC HEALTH AND HUMAN SERVICES

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Room 400, City Hall
Philadelphia, Pennsylvania
Tuesday, April 25, 2000
2:25 p.m.

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RESOLUTION 000172 - Authorizing the Committee on Public Health and Human Services to hold public hearings in order to evaluate and assess the adverse health effects caused from exposure to secondhand smoke. . .

PRESENT: COUNCILWOMAN MARIAN B. TASCO, Chair
COUNCILMAN FRANK DICICCO
COUNCILMAN RICHARD T. MARIANO
COUNCILWOMAN DONNA REED MILLER
COUNCILMAN ANGEL L. ORTIZ
COUNCILWOMAN BLONDELL REYNOLDS-BROWN
COUNCILMAN FRANK RIZZO

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4/25/00 PUBLIC HEALTH & HUMAN SERVICES

I N D E X

(* - Written Testimony Also Attached.)

Attached Written Testimony Only

Alice Dalla Palu, Executive Director, Coalition for a Smoke-Free Valley

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P R O C E E D I N G S

COUNCILWOMAN TASCO: Good afternoon. I'd like to now call the Committee on Public Health and Human Services to order, and I'd like to state that we have a quorum in the presence of Councilman Goode, Councilman Nutter (the sponsor of this bill), Councilman Mariano, and myself.

We'd like to clerk to read the resolution.

THE CLERK: This is Resolution No. 000172, authorizing the Committee on Public Health and Human Services to hold public hearings in order to evaluate and assess the adverse health effects caused from exposure to secondhand smoke by taking testimony from health organizations, health advocates, public health officials, by reviewing reports and studies published by federal and state government agencies and institutions, educational institutions, and health research organizations; by the examining the approaches adopted by other cities and states to limit the public health risks associated with exposure to secondhand smoke; and by discussing and analyzing policies which would address the public health

concerns associated with exposure to secondhand smoke in order to protect the health of the citizens of the City of Philadelphia.

COUNCILWOMAN TASCO: Thank you very much.

This resolution has been sponsored by Councilman Nutter, and he would like to make brief opening remarks. The Chair recognizes Councilman Nutter.

COUNCILMAN NUTTER: Thank you, Madam Chair and good afternoon.

This is a resolution that I introduced and that is actually cosponsored by virtually all members of City Council. This is a resolution authorizing the Committee to take testimony about the effects of secondhand smoke.

This is not a bill, it is not a matter that is pending before the Council to take any particular action other than to hear from health-care officials, public health officials, citizens. Anyone is free to testify. As Councilwoman Tasco, I'm sure, would tell you, at a Council public hearing, if you wish to testify and if you have not already contacted either my office

or the Chair's office, we'd be glad to add your name to the list to hear as much about this particular issue, regardless of what anyone's viewpoint may be. It is important to the Council to get as much information when we are conducting this kind of hearing.

So I appreciate everyone's participation, and we look forward to hearing your testimony. Thank you very much.

COUNCILWOMAN TASCO: Thank you, Councilman Nutter.

Councilman Nutter's office has prepared the witness hearing list, and if anyone else chooses to or would like to testify, they can see Brenda Frazier here, and we can add your name to the list.

They have organized the witnesses in categories. And our first witness to talk about -- give us the overview of adverse health effects is Dr. Robert Simmons, American Heart Association, and others.

(Witness comes forward.)

DR. SIMMONS: Thank you very much. You prepared comments that you I copies distributed

for the overview, and I appreciate the opportunity to come before you today.

My name is Robert Simmons, and I currently am the Director of Government Community Relations and Health Education with Christiana Care Health System, out of Wilmington, Delaware. I'm a health educator, in practice since 1973, but I come to you today as a representative of the American Heart Association, from the Pennsylvania Delaware affiliate, I serve on the Board of Directors, and I am the Advocacy Chair.

My work in tobacco control spans over 25 years, most of which were in California. Prior to coming to the mid-Atlantic region four years ago, I served as the Manager of California's Environmental Tobacco Smoke Initiatives, which included AB-13 which was the initiative you may have heard about that restricted smoking in restaurants and bars in the state, the first ever.

A couple of definitions -- I won't spend a lot of time with that, but I just want to emphasize a few sort of historical perspectives, and I was asked to provide some of that background with you today.

Tobacco, as you know, is a native tropical American plant used for leaves and can be smoked in cigarettes, cigars, or pipes, and also used in a smokeless form. Beginning in the 20th century, the most common form of tobacco use in the United had been through smoking, particularly with the advent of cigarette-rolling machine in the late 1880s. And that's really the unique aspect of this behavior, that's something that we have yet to recognize, is that the uniqueness of this behavior in the smoking of tobacco is that it automatically creates environmental tobacco smoke.

Tobacco smoke has been known as a classified -- excuse me, as me Group A carcinogen, a rating used only for substances known to cause cancer in humans. There are over 4,000 known chemicals in tobacco smoke, 51 of which now been classified or identified as to their carcinogenicity, reproductive toxicity, or other health hazards, including such compounds as benzine, carbon monoxide, DDT, nicotine, vinyl chloride, arsenic, and lead.

Environmental tobacco smoke, or ETS --

or another name is "secondhand smoke" -- is a complex mixture formed from escaping smoke of a burning tobacco product (termed as "sidestream smoke") and the smoke exhaled from the smoker. So it's really -- two aspects of ETS are environmental tobacco smoke. The exhaled smoke and the sidestream smoke was the most damaging from the burning cigarette or pipe or cigar. The characteristics of ETS change as it ages over time. And the exposure is frequently called, or termed, "passive smoking" or "involuntary smoking."

A very brief history of the studies. The studies on environmental tobacco smoke have basically paralleled with about a 20- to 25-year lag from the studies of cigarette-smoking, but it's very similar in its form, on the tramline as we've moved ahead in the sophistication of the scientific studies on environmental tobacco smoke.

The first Surgeon General's report in 1964 on cigarette-smoking, referred to as -- in a sense, there were suspicions or thoughts that there might be, with significant exposure to ETS, it's maybe more than just a nuisance to

nonsmokers; it may actually have a serious health effect. Their earlier studies occurred, of course, with animals, and then one of the -- the first studies actually were dealing with nonsmoking wives from the Japanese and also a Greek study that were reported in the late 1970s -- actually, 1980-'81, I believe -- that looked at large studies of population. In the Hira Yama study, over 90,000 Japanese wives who were nonsmokers were compared to others Japanese wives who were nonsmokers, and the only differences is that some were married to smoking husbands and others were not. And it was a large sample and they showed a significant correlation between lung cancer of those wives who were nonsmokers who were married to smokers, but there was no measurement of level of exposure or anything like that at that early time.

In the early 1970s and 1980s, individual components of tobacco smoke have become further identified, and methodologies to measure the rate of ETS exposure by nonsmokers have been developed. Studies on specific highly exposed populations were instituted, resulting in further

defined levels of ETS exposure, and subsequent estimates of excess morbidity and mortality of nonsmokers due to that exposure. Studies on adverse effects and respiratory outcomes of children and adults, acute cardiovascular effects associated with ETS exposure were summarized at the national level first in the 1979 U.S. Surgeon General's report on cigarette-smoking, which was the 15-year history since the first in '64.

The culmination of ETS studies in the 1970s and early '80 resulted in the first definitive summary report on health consequences of involuntary smoking. In 1986, the first Surgeon General's report on it showed a potential causal relationship between ETS exposure and excess morbidity and mortality.

More recent history. Numerous studies have reported these causal links of ETS exposure to low birth weight poor fetal growth and development, Sudden Infant Death Syndrome, asthma, lung cancer, ischemic heart disease, middle-ear infections, lower-respiratory tract infections, eye and nasal irritation, among other diseases, and poor outcomes. And there's a whole lot of

references for you from those studies.

What's key, what's key that I wanted to mention is when they talk about causal link is the fact that you're able to adjust -- in large populations, you're able to adjust for other environmental factors, other environmental factors, genetic factors, and other socio-demographic factors, so you have comparison populations and you can then conclude that there was no other explanation except for the significant exposure of ETS.

Well, what about the extent of the exposure? The early studies, as I mentioned, looked at nonsmoking family members and what impact that might have in the home. What's really significant is that in the late 1980s, in the 1990s, there's been extensive studies on workplace exposure that have been conducted. A meta-analysis of these studies have concluded that lung cancer and heart disease risk from passive smoking at work is roughly equal in level of exposure to long-term household exposure. So initially the thoughts were it was the -- being in the household was the main level of exposure and

the main risk, but the further studies have shown now that extensive exposure to workplace had a significant impact as well and roughly equal to that.

Nicotine and cotinine, which is a major metabolite of nicotine, are the most widely used, what we call "biochemical markers of ETS exposure." Recent studies on casual exposure of ETS -- this would be the exposure that you would get from a 45-minute to 1-hour exposure at a restaurant or other public facility. Recent studies on that exposure have shown significantly higher levels of cotinine in nonsmoking individuals from such exposure. This is measured either in the blood, saliva, or urine. And that's really significant, the fact that -- a conclusion drawn from these studies is that even casual exposures in a one-hour period or less will result in these cotinine or nicotine, for example, in the blood extreme for several days. So that's a major change in the level of sophistication of the studies from the long-term exposure to casual exposure.

COUNCILMAN NUTTER: Doctor, I'm sorry

to interrupt you.

DR. SIMMONS: Yes?

COUNCILMAN NUTTER: Can I just make sure that the record is clear. The word that you're using is C-O-T-I-N-I-N-E.

DR. SIMMONS: Cotinine, yes.

COUNCILMAN NUTTER: Cotinine?

DR. SIMMONS: Yeah.

COUNCILMAN NUTTER: Not to be confused with "codeine."

DR. SIMMONS: No, no. "Cotinine."

COUNCILMAN NUTTER: Cotinine.

DR. SIMMONS: Right.

COUNCILMAN NUTTER: I heard that a couple times -- it went by me pretty quick, and I just wondered.

DR. SIMMONS: Sorry. I'm glad I could clarify that. That's also used as the standard marker in the evaluation of studies and research for smoking cessation -- you measure cotinine levels. There's other things you can use, like carbon monoxide, but cotinine is a much better marker to be able to determine exposure to ETS.

Okay, as far as the societal reaction

to ETS, it's been a long history of that. Initially, the concern about ETS was not related to health but related to fires and linkages to chemicals and combustible fluids and things like that. Beginning in the early 1970s, government and private industry began to restrict smoking in public places for health purposes. Smoking was prohibited in markets with fresh produce, in small enclosed areas such as elevators and other types of small enclosed areas. In 1975, Minnesota became the first state to have a statewide comprehensive ETS law that protected nonsmokers.

By 1980, separation of smokers and nonsmokers became standard practice in government buildings, public transportation and air travel, health-care and child-care facilities, and many private businesses. After the release of the 1986 Surgeon General's report on environmental tobacco smoke, with the causal studies and the results that were shown, a number of those organizations, private and public agencies, determined to prohibit entirely smoking in indoor environments.

And what's crucial there is -- and the best evidence, of course, that we have is what is

happening in the airline industry, when recognizing that just separation between smokers and nonsmokers, when you measure the cotinine levels of those nonsmokers with a casual exposure, they show significantly high cotinine levels. So the concept of pure separation did not result in a lack of exposure, significant exposure on the part of the nonsmokers. So that's a major aspect of the study and it has a lot to do with the sophistication of our processes and methodologies and research.

Recognizing the rapid increase in smoking restrictions is a serious threat to what was either favorable or at least neutral public attitudes towards smoking and to tobacco consumers. The tobacco industry expanded its public advocacy activities in the 1980s. They no longer focused on the cigarette-smoking. They pretty much -- after 20 years of debating the Surgeon General's reports about that, they changed their perspective and policy and their promotions, and focused instead on environmental tobacco smoke, saying -- basically saying that the studies that were done by the U.S. Surgeon General's

Office and the many other scientific studies and the Environmental Protection Agency were not valid, and there were a number of reasons for that.

I think it's quite interesting today that they ended up then focusing on blocking local ordinances and local jurisdictions. A large number of local cities and local groups decided to take their own initiative to protect their citizens as far as ETS is concerned. And one of the ways that the tobacco industry did that, of course, is to create state preemption. To date, 17 states have preemption laws on environmental smoke that preempts any city or local community or county from developing an ordinance that would be more stronger than the State ordinance.

I think it's quite interesting -- you may have heard that the tobacco industry's just released a new cigarette, it's actually a revised cigarette, called "Eclipse," which is no longer a -- it's not a burning product, it's a heat-producing product. And what's interesting about that is, the industry itself has stated that there is 80 percent in ETS, so it's very evident that

the tobacco industry is very aware of the seriousness of this product and the ETS exposure.

Do you have a question, Councilman?

COUNCILMAN NUTTER: Just a quick request. Doctor, is it possible that you might be able to skip right to the -- you have a summary of what we know today about ETS and --

DR. SIMMONS: Sure can.

COUNCILMAN NUTTER: And your entire testimony will be entered into the record as if it were read.

DR. SIMMONS: I apologize for taking as much time as I have.

COUNCILMAN NUTTER: Sure, it's no problem.

DR. SIMMONS: Basically, the summary of this -- and you're going to hear a lot more specifics from the group of people that have been put together in today's hearing. But basically to summarize -- that's on Page 4 -- the effects are the following:

Developmental effects -- strong causal relationship with ETS and low birth weight, Sudden Infant Death Syndrome;

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A significant number of respiratory effects -- and you can see those on lower-respiratory effects such as asthma induction and exacerbation;

Respiratory chronic symptoms in children, such as middle-ear infections, etc.;

Carcinogenic effects, with lung cancer and nasal sinus cancer;

Cardiovascular effects, etc.;.

And then there's suggested evidence, and I separated those out because that's a little bit less specific in the studies: developmental effects, respiratory effects, and carcinogenic effects.

And, finally, on the last page, I included estimates that are -- as far as range of morbidity and mortality. And you can see the incredible numbers of cases, whether that's middle-ear infection, the numbers of visits to physicians' offices due to middle-ear infections or asthma exacerbation, bronchitis, pneumonia, lung cancer, and heart disease.

Between 35,000 and 62,000 deaths annually in the United States are due to

environmental tobacco smoke. We do not know what the economic costs are, but they're obviously in the billions of dollars.

And so the question that city governments and state governments and policy-makers have is to decide what they want to do, what role government has in looking at this data that we now have and is appropriate.

So I want to thank you for the opportunity to present to you. If you have any questions, I can answer them.

COUNCILWOMAN TASCO: The Chair recognizes Councilman Rizzo. I'd like to recognize that he is a member of the committee and is a part of the quorum.

COUNCILMAN RIZZO: Thank you.

DR. SIMMONS: Councilman?

COUNCILMAN RIZZO: Doctor, could you elaborate, if possible. Technology, you go into many areas where there's ETS and you see these smoke-eaters and these devices that are supposedly helpful in minimizing or lessening secondhand smoke. Do they work, are they effective?

DR. SIMMONS: I don't think there's

been any definitive studies on all the various makes and brands of those types of devices. What the conclusion of the EPA report has been is that simple separation, no matter what devices are used, do not completely eliminate the health risk of environmental tobacco smoke, and that the best devices that I've seen and have been studying have not been in public places like restaurants and stuff but actually in major chemical companies, where they have very large, tens of thousands of dollars worth of equipment to eliminate those types of smoke. And there has been some studies on that.

But the things that would be utilized in a restaurant or in another public place, there have been no studies that I know of that have significantly looked at that, except to say the conclusion was that simple separation does not work, and that what is recommended by the Environmental Protection Agency is that you need two separate enclosed areas with separate ventilation systems so that the ETS is not drawn back into, through the same ventilation system, into another room.

COUNCILMAN RIZZO: Okay, thank you.

DR. SIMMONS: Mm-hmm.

COUNCILMAN RIZZO: Thank you. Thank you, Madam Chair.

COUNCILWOMAN TASCO: Any other questions?

(No further questions.)

COUNCILWOMAN TASCO: Thank you very much for your testimony.

The Chair recognizes Dr. Jay Greenspan and also Dr. English Willis, and Dr. Jennifer Culhane.

(Witnesses come forward.)

COUNCILWOMAN TASCO: You may all come to the table at the same time; you are sort of a panel.

DR. GREENSPAN: Dr. Culhane couldn't make it today, I'm sorry.

COUNCILWOMAN TASCO: Okay, thank you.

DR. GREENSPAN: Thank you very much for inviting us. My name is Jay Greenspan, I'm Director of Neonatology at Jefferson Medical College, and I'm also on the executive committee of the Southeastern Pennsylvania Chapter of the

March of Dimes, as the March of Dimes' mission is to prevent infant mortality and birth defects, and so in both my role at Jefferson as well as my role in the March of Dimes volunteer work in March of Dimes, it's appropriate that I be talking to you about environmental smoke and its effect on the fetus, and I hope to see all of you at our walk this Sunday for the March of Dimes.

I have passed out a synopsis of what I'm going to say today, and I also have given to Council a book with the original research that you could look through if you wish.

The fetus and the infant are never primary smokers -- hopefully never primary smokers -- and so they have been subjected to a secondary smoke through usually the home environment. The fetus has never really been considered until recently to be a victim of secondhand smoke because, after all, the fetus doesn't breath in utero technically, and it seems hard to imagine that smoke would actually get into the womb and affect the fetus.

However, we do know that the fetus is very capable of basically being the perfect

parasite on a mom, where the fetus will suck every nutrient out of the mom possible to ensure proper growth, and that's how they get through some very rough times and turn out to be relatively healthy. Even in the worst of environments. That attribute of the fetus has led them to have problems where they will also suck out some of the toxins, for instance, that their moms are exposed to, and smoking has been one of the toxins that has been relatively recently noticed to have a relatively severe effect on the neonate.

I will be concentrating in my brief time on the effect of the unusual environment where a mother who does not smoke -- so the fetus is not secondhand-smoking from the mother, that's a different story that we know a lot about -- to the story where a mom who is pregnant is in a workplace environment or in a home and is exposed to secondhand smoke. So this is a more distal relationship where the mother is the secondhand smoker -- what is the effect on the fetus? And secondarily, I will talk a little bit about the effect on the infant up to a few months of age in relation to the Sudden Death Syndrome.

Even with this very remote contact of the fetus to the secondhand smoke of the mother, we have realized over the past couple years that there are serious and damaging effects on the fetus, just by the mother breathing in secondhand smoke. And this was summarized by a recent study out of Johns Hopkins that reported in their conclusion that "there is consistent evidence maternal relating ETS exposure to an increased risk of adverse pregnancy outcomes and that this association may be generalized to the work environment. . . (Therefore) ETS exposure in the workplace can and should be minimized to protect pregnant women for its adverse effects.

What are some of the specific problems that have been noticed by maternal relating ETS in the effects on the fetus? I will talk about a few of them.

What is the effect on the fetus if a mother is secondhand-smoking? Well, there's been some studies that suggest that mild exposure to secondhand smoke for less than an hour a day or low levels may or may not affect fetal growth -- we're not sure of that. But we do know that if

there is significant secondhand smoke exposure to the point of more than an hour, about an hour or more a day -- which is not a lot but still is some exposure -- that the baby could lose up to an ounce of weight compared to controls. And other studies, less well controlled, have suggested up to three ounces of weight would be lost due to secondhand smoke.

What does fetal growth have to do with anything? I mean, can't you assume that the baby will just catch up? Well, in fact, we know that small babies are at increased risk for many other problems throughout their lives. They are always so much smaller than their counterparts. There is some discussion about developmental delay in these babies. And so basically what's happening is, the toxins from the smoke, even through secondhand smoke, is getting to the fetus, stunting growth probably both in the cell number and in the cell size, which affects development, and other things that go on that are probably long-lasting throughout their lives.

What's happening to the baby's lungs? Now, the fetus is not breathing in the smoke, so

how can it be affecting the lungs? Well, we have learned actually through studies on the fetus that the effect on our lungs when we spoke secondhand smoke is probably not just related to smoke hitting our lungs, but it's the toxins that get into the blood stream and then affect the lung. And that is what's happening to the neonate. We've known that secondhand smoke to the neonate affects their lung airway growth, and so airways that are growing abnormally because of exposure to secondhand smoke will stay abnormal throughout life and will predispose them to problems such as asthma later on, which Dr. Willis will be talking about.

In addition, we have related secondhand smoke to something called "pulmonary hypertension in the newborn," and that's when the blood vessels are tightened in the newborn and that's not -- and it compromises their ability to breathe once born. And, in fact, that is one of the causes of infant mortality in the newborn, period, and is something that clearly we want to avoid. The reason behind secondhand-smoking causing pulmonary hypertension in the newborn is not clear but it's

clearly been related to secondhand smoke in several preliminary studies.

We have known for some time that secondhand smoke relates to Sudden Infant Death Syndrome, and even though we have been very successful over the past five years at diminishing Sudden Infant Death Syndrome, it still remains the leading cause of infant mortality beyond the neonatal period in this city. And, in fact, secondhand smoke has been suggested to give a fourfold greater risk of Sudden Infant Death Syndrome.

The possibility that a mother exposed to secondhand smoke brings it home from the workplace and affects their child or a father has been entertained, to be honest, there's been no evidence that that exists, but it certainly is a potential concern.

Just to point out some -- one very frightening study was out of Vermont in 1998, where they actually studied some very elaborate blood tests in mothers exposed to secondhand smoke in the workplace, and they looked at the blood of their child and found indicators suggesting an

increased tendency towards malignancy in early childhood, which is a very frightening study, and although the data was somewhat preliminary, it certainly sent shock waves through the medical community talking about the risks of environmental smoke to pregnant mothers -- to the fetus of pregnant mothers.

There have been some animal studies looking at secondhand smoke. I will summarize it just to say that, clearly, the largest effect of secondhand smoke on the animal litters has been on size, and that will be up to a 25 percent decrease in litter size in rats, but other problems in their organs have also been found.

So I think in summary -- and I think you'll see the data can be found in that booklet I've given you -- the risks of secondhand smoke are becoming increasingly clear to the fetus and certainly to the infant. And I think that we would agree with the conclusions brought out by the study out of John Hopkins that certainly in the workplace, ETS exposure should be avoided by pregnant women at all costs.

DR. WILLIS: Hi. Thank you. I'm

English Willis, and I am here under really two hats. One is, I'm one of the pediatric advisers for the Clean Air for Health Children's Program. It's a program that is funded by the Pennsylvania Chapter of the American Academy of Pediatrics. And this program is designed to health-care professionals on strategies to offer smoking cessation the their patients, smoking cessation counseling. And I'm also a pediatrician, and I work at == I am at Pennsylvania Hospital as a medical director for the Women and Children's Health Service. I've been a primary care provider for probably the last 20 years. So I've seen the effects of smoking on children and following their health on a continuity basis.

In 1995, it was reported that 25 percent of American adults smoke. We know that in Pennsylvania, the number of non-pregnant women is high, with 22 percent of those women reporting smoking, and 17 percent of pregnant women report to smoke. We also know that these numbers are falsely low because most women are not going to admit that they smoke when asked by their physician, and they're not going to record this on

any documents.

As a result of this, 43 percent of American children between the age of 2 months and 11 years of age live in a home with at least one smoker and are at risk for the adverse effects from this exposure. Young children are at a significantly exposure risk because of the amount of time spent indoors. The exposure to children is from a variety of environments, including their homes, the homes of relatives, child-care settings, public and recreational facilities and motor vehicles.

Environmental tobacco smoke, as has been mentioned, contains numerous amounts of chemicals. We know that cotinine has been detected in 50 percent to 88 percent of nonsmokers exposed to environmental tobacco smoke and has also been found in the body fluids of infants of smoking parents.

There is extensive research on the adverse health effects of environmental tobacco smoke on infants and children. In addition, in 1996, the American Academy of Pediatrics Committee on Environmental Health has reported and outlined

the hazards of environmental tobacco smoke on children and made ten recommendations.

The in utero -- in addition to the in utero effects, children exposed to environmental tobacco smoke experience higher rates of lower-respiratory tract infections, increased rates of ear infections, worsening of asthma symptoms, and burns deaths or fires initiated by smoking materials. Lower-respiratory tract infections include pneumonia, bronchitis, and bronchiolitis, which are higher in children exposed to ETS. These children are 57 percent more likely than non-exposed children to contract lower-respiratory tract infections during the first three years of life.

Infants whose mothers smoke are 38 percent more likely to be hospitalized during the first year of life for pneumonia than those whose mothers do not. The effect is dose-related, with an increase in the number of hospitalizations as the number of cigarettes smoked by the mother increases each day. For children residing with two smokers, the risk doubles.

Sixteen percent of doctor's visits for

evaluation of cough are attributed to environmental tobacco smoke. Illnesses caused by acute nasopharyngitis sinusitis were 1.5 times more likely to occur if the mother smoked.

In utero exposure for maternal smoke and postnatal exposure of ETS adversely affects lung growth and development in children. As Dr. Greenspan just mentioned, it causes a reduction in small airway flow rates, and that reduces lung function, and we know that this persists into adulthood.

Ear infections have become far too common infections suffered by millions of children. Middle-ear effusions, or fluid inside the eardrum, is a common reason for surgical hospitalization and the most common cause of deafness in children. Research studies report a 37 percent increase in the risk of recurring ear infections and a 48 percent increase in the risk of middle-ear effusion in children exposed to ETS. The risk is not limited to infancy; we know that up to one-third of the cases of middle-ear effusion in children six to seven years of age attributed to exposure to ETS.

Asthma is now the most common chronic lung disease in children, affecting 2 million to 5 million children in the U.S.. Asthmatic children exposed to ETS experience a decrease in lung function and an increase in airway reactivity, resulting in more frequent and more severe attacks, greater medication use, and more missed days from school or work for both the child and the parent. These children also experience higher rates of hospitalizations and more frequent exposures to life-threatening bronchospasm. Studies have also reported that children exposed to ETS have a higher-than-average risk of wheezing that is not related to asthma.

Many studies have linked exposure to ETS to lung cancer in nonsmoking adults living with spouses who smoke. A group of researchers have also found that leukemia and lymphoma among adults were significantly related to exposure to maternal ETS before the age of ten years.

Philadelphia, like other cities, mourns the death of children every year that die in house fires initiated by smoking materials.

The evidence is overwhelming that

tobacco products place an enormous burden of illness on children and on the unborn, far greater than would be tolerated from any other product. To protect children and youth, smoking should be banned in schools and on school properties, child-care centers, family child-care homes, restaurants, and public places.

Organizations that cater to children should guarantee that they have a smoke-free environment, and health-care providers should educate parents and caregivers on the hazards of environmental tobacco smoke and provide guidance for smoking cessation.

Thank you.

COUNCILWOMAN TASCO: Thank you very much, both of you for your testimony.

Are there questions from members of the committee?

(No questions.)

COUNCILWOMAN TASCO: Thank you very much.

DR. WILLIS: Thank you.

DR. GREENSPAN: Thank you.

COUNCILMAN NUTTER: Thank you.

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COUNCILWOMAN TASCO: The next panel will talk about the adverse health effects on adolescents and adults: Dr. Frank Leone, Dr. Clark Piatt, Nurse Marcia Winston, and Leah Gibson.

(Witnesses come forward.)

DR. LEONE: City Councilmembers, ladies and gentlemen of the committee, thank you for the opportunity to speak to the committee today on the subject of secondhand smoke. I'm grateful for the opportunity to offer some insight into the nature of a health problem that has plagued my patients in a very meaningful way for many decades.

COUNCILWOMAN TASCO: And you are?

DR. LEONE: Frank Leone, I'm sorry.

COUNCILWOMAN TASCO: Thank you.

DR. LEONE: I serve, actually, both as a board member for the American Lung Association of Pennsylvania and chair of their Governmental Affairs Committee. And I also direct Jefferson's Center for Tobacco Research and Treatment. But, fundamentally, I want you to think of me as a lung doctor.

As a respiratory specialist, my

practice is made up primarily of patients who suffer from the effects of smoking. However, a large portion of my practice is dedicated to the care of asthmatics. Some asthmatics, as you are aware, suffer directly from the effects of cigarette-smoking themselves. This is certainly concerning. However, of equal concern are the adverse effects that several million asthmatics endure annually in the United States, induced by the indirect exposure to tobacco smoke via environmental contamination.

What better place than Philadelphia, "the Cradle of Liberty," to recall that tobacco was first exported to England in 1613. Several years later, in response to a growing demand, King James I criticized the new colonial arrival by stating that tobacco was "loathsome to the eye, hateful to the nose, harmful to the brain, and dangerous to the lungs." The king's prescience was irrelevant in the 17th and 18th century, however, for tobacco rapidly became the mainstay of colonial economics.

Today, nearly 400 years later, we gather to discuss what King James intuitively

knew. Involuntary smoking by nonsmokers who breathe environmental tobacco smoke is the third leading preventable cause of death in the United States. You will, no doubt, hear about many such health effects during the course of this testimony, but I will be restricting my comments to the effects of ETS on adolescent and adult asthmatics.

Environmental tobacco smoke is indeed very dangerous to the lungs. Asthma is a disease that is characterized by airway inflammation, and it manifests itself as an increased responsiveness to a variety of environmental stimuli. The prevalence of asthma has increased dramatically over the past 20 years, and exposure to ETS has been repeatedly implicated in adolescent exacerbation of asthma. In fact, environmental tobacco smoke has even been implicated as a potential cause of asthma in some people.

Asthma causes the greatest health consequences among inner-city youth. In fact, in a study published in 1994, asthma deaths in Philadelphia went up during the observation period of 1969 through 1991. That study was published

from Hahnemann University. In addition, poorly controlled asthma has been the cause of millions of dollars in excess medical expenditures in this city.

Twenty percent of U.S. patients with asthma experience worsening of control because of involuntary smoking. Of these, ETS is classified as a major contributing factor in 10 percent. The U.S. Environmental Protection Agency has estimated that as many as 26,000 new cases of asthma each year may be attributable annually to exposure to parental smoking. If you conservatively assume that the effect in Philadelphia is proportional to the national data, there are 365 new cases of asthma in our city every year that can be attributable to environmental tobacco smoke. That's one new asthmatic every day, and that's because of involuntary smoking.

Consensus from recent literature reviews and meta-analyses have confirmed and reinforced previously held views that involuntary smoking adversely affects our youth. But what about adults? We all inherit the basic genetic code that determines the likelihood that we'll

develop certain attributes as life goes on. Just like eye color, you've inherited from your parents the infrastructure which will determine your risk for some diseases.

With adult asthma, a genetic inheritance has been proven through large population studies. However, unlike eye color, actually developing the asthma is considered dependent on exposure to environmental allergens and irritants such as ETS.

Environmental tobacco smoke increases the frequency and severity of asthma symptoms among adolescents and adults with established disease. In effect, ETS reduces control of the airway inflammation and probably translates into more medicines, more doctor's visits, more emergency department utilization, and more hospitalizations.

These latter assumptions are a bit difficult to prove but are widely accepted. The effect of ETS on control of asthma in adults is supported by several observations, including: there's an association between involuntary smoking and variability in lung function measurements; the

variability in lung-function measurements is a well-accepted marker of airway inflammation, and that relationship has been firmly established.

Among children hospitalized with bronchiolitis -- bronchiolitis is a temporary inflammation of the small airways of the lung. Those children who have smoking parents are over twice as likely to develop asthma as adults, when compared to children similarly hospitalized with nonsmoking parents.

Exposure to ETS predicts reduced lung function compared to that which is expected for similar non-exposed patients. There are very few absolutes in medicine, and there's very few predictable values in medicine. It turns out lung function is one of the most predictable things we have. Knowing your age, your height, your gender, and your racial background, I can tell you within a very precise confidence interval what your lung function should be. In fact, patients who are exposed to environmental tobacco smoke have a decline in lung function compared to those predicted values.

Finally, in a study of adult asthmatics

enrolled in a managed-care plan, those exposed to ETS experienced a decreased asthma-related quality of life and were more likely to utilize hospital services than those unexposed to ETS.

Because of these studies and others like them, management of the asthmatics environment is considered an integral part of patient care. In 1997, the National Heart, Lung and Blood Institute published a comprehensive set of guidelines in the care of the asthmatic patient, both children and adults. Prominently featured is an admonition to providers to help asthmatics avoid both direct and indirect exposure to tobacco smoke. However, very few doctors actually heed this advice. Perhaps it's partly due to their frustration, perhaps it's partly due to the ubiquity of the problem.

Please help me help my patients. Make the air they breathe a little safer for them and make the environment they live in a little less deadly. ETS has indeed been contributing to the problems I face in the care of my asthmatic patients every day. Remember that one in five asthmatics have an exacerbation of their symptoms

because of ETS, and that for 1 in 50, ETS is considered a major contributing factor.

Consider the direct and indirect financial as well as the human costs of this problem as it currently exists, and the answer becomes obvious. Legislation designed to reduce our exposure to the effects of involuntary smoking can significantly impact the lives of hundreds of thousands of asthmatics in this city. Maybe we don't have to get to know that one new ETS asthmatic every day.

Thank you again for the opportunity to talk to you, and I'll make myself available for questions as you see fit.

COUNCILWOMAN TASCO: Thank you very much for your testimony.

Doctor, would you identify yourself for the record, please.

DR. PIATT: Certainly. Good afternoon. My name is Dr. Clark Piatt, and my specialty training is in pulmonary and in critical care and sleep medicine, and my practice is based at Temple University Hospital.

The focus of my testimony today

concerns the dangers of passive smoking, or environmental tobacco smoke, and I'll pretty much talk on what Dr. Leone has already covered, but more focused toward the adult.

Over the last 40 years, overwhelming evidence has shown that smokers are at a higher risk for developing coronary artery disease, lung cancer, emphysema, and chronic bronchitis. Untold, however, is the toll paid by Americans that are exposed to secondhand smoke during the course of their everyday lives.

There is mounting evidence that exposure to secondhand smoke can have profound untoward health effects on the nonsmoking population. Indeed, a study that was done by the California Environmental Protection Agency in 1997 estimated that in the United States, environmental tobacco smoke exposure caused 3,000 deaths per year due to lung cancer and 50,000 additional deaths due to ischemic heart disease. Countless more in the adult population -- at least the nonsmoking population -- can develop or exacerbate chronic respiratory ailments, including emphysema, chronic bronchitis, and asthma, by exposure to

secondhand smoke.

Of note, environmental tobacco smoke itself contains even more particles than that inhaled during active smoking. The Environmental Protection Agency considers these particles within the same classes of carcinogens, radon, and asbestos.

So today, what is the evidence concerning the danger of passive smoke? Concerning lung cancer, we know that active smoking today is responsible for the majority of the lung cancer diagnosed in the United States. A review of the data in a 1997 study published in the British Medical Journal revealed that among nonsmokers that were exposed to secondhand smoke, there was a 24 percent increase in the incidence of lung cancer. Both the amount of cigarette use in the household or workplace and the total time of exposure were related to the cancer risk. Studies have also shown, that were mentioned earlier, that spouses have an increased risk of lung cancer living with a person who has a smoking history.

As for coronary artery disease, we know

that active cigarette-smoking is one of the most important modifiable risk factors in the development of the coronary heart disease. A 1999 study that was published in the New England Journal of Medicine demonstrated that nonsmokers that were exposed to environmental smoke in the home or the workplace had an increased incidence of coronary artery disease. This, together with other studies, including ones in the British Medical Journal, put this rate of approximately 25 percent increase in the development of early atherosclerotic coronary heart disease as a result from environmental tobacco smoke exposure.

As far as emphysema and chronic bronchitis, these breathing together are known as "COPD," or chronic obstructive pulmonary disease, affect millions of Americans and are often directly related to smoking use. Symptoms in these patients typically start with cough or shortness of breath and often have an insidious progress. Over years of continued exposure to the tobacco smoke, many with COPD become severely disabled, often each moment struggling for breath, awaiting an early death.

We as physicians recognize that exposure to secondhand smoke can contribute to these diseases. Effects have been studied in workers that have been exposed to high levels of smoke, including flight attendants, casino workers, restaurant and bar workers, concluding that they are among the highest risks for respiratory problems. And in one 1993 meta-analysis in the Journal of the American Medical Association, environmental tobacco smoke was found to be two times higher in restaurants and up to five times higher in bars than in other businesses surveyed.

There was a recent study that I reviewed by Eisner in the Journal of the American Medical Association that found that after a smoking ban was put into place in California, the bar workers had a marked decline in respiratory symptoms overall. These included decrease in wheezing, shortness of breath, cough, and mucus production. They also had significant improvement in their lung function that was measured over time.

Similar studies have shown additional

benefits, that being economic, from smoking restrictions in the workplace, with decreased time off from work, in addition to fewer medical visits needed.

There was also a 1999 study in the respiratory journal Chest, done by Bergman (ph.) That specifically looked at older nonsmoking adults with COPD and attempted to demonstrate why these patients would develop COPD out of the blue. They ultimately concluded that of these patients, smoking exposure increased the risk by 50 percent of developing COPD.

In summary, the impact of secondhand smoke on our society is clear: it is a health hazard. In adults, they're at increased risk for lung cancer, coronary artery disease, and chronic obstructive pulmonary disease, with the time and amount of smoking related to increasing the risks. Patients with underlying respiratory diseases like asthma are at risk for increased symptoms from environmental smoke. I'm told in my testimony but heard earlier that there are problems at least of respiratory and developmental problems within the children and fetus exposed to cigarette smoke.

The economic impact of all of this has really not been well calculated, but considering that virtually all Americans are at least exposed to secondhand smoke, you can imagine the cost of the health care and lost work are considerable.

As physicians and legislators, we must have continued efforts to educate the population about the dangers of passive smoking and to enact protections for the nonsmoking population, especially those at greatest risk.

Thank you. I'll take any questions you may have.

COUNCILMAN NUTTER: Thank you.

COUNCILWOMAN TASCO: We'll wait till everyone has spoken, and then we'll open the panel for questions.

Would you please identify yourself for the record? Do you have testimony?

MS. WINSTON: Yes. Hi. I'm Marsha Winston. I'm a pediatric nurse practitioner in pulmonary medicine at Children's Hospital of Pennsylvania.

I think I'm going to take you on a little bit of a different direction. I think,

looking at the research that's certainly been reviewed in deputy already, we know that exposure to secondhand smoke is dangerous. It's dangerous to children without lung disease and it's certainly dangerous to children with lung disease.

But I'd just like to review what I'm up against when I see patients. I've been in pulmonary medicine for five years, and I've seen hundreds of patients. And with every single patient, this is an issue that we need to address. So when we're seeing a patient in pulmonary medicine for the first time and we're reviewing the medical history, part of that is asking whether there's any exposure to secondhand smoke in the home.

This is a very difficult issue to discuss with parents. If you take the wrong tact with parents in discussing it, they become defensive and you can't make a connection with them, and they're never going to listen to another word you say, and maybe not take your recommendations for treatment for their children.

The reason that it's such a difficult issue to discuss is that I think that a lot of

parents have guilt about their own smoking, whether it's guilt about addition to smoke, whether it's guilt about the money they're spending, or whether they can even have guilt feeling that "I'm doing something that's harmful to my child" to the point that, one, "I'm bringing them to a subspecialist." By the child's seeing a subspecialist for respiratory complaints, whether it's cough, pneumonia, asthma, they've probably been in the emergency room quite a few times, been on a lot of medication, possibly been in the hospital. So parents generally have a lot of guilt when it comes to discussing their own smoking habits.

Most parents will tell you, even by the time they come to us, that they smoke outside the home, but I think if you go through neighborhoods where you know there's a lot of smoking, you don't see all the parents who smoke, you know, sitting outside. You know that they are smoking in the home.

The other thing that makes it difficult when talking about this topic with parents is, they don't necessarily see the effect that I'm

smoking a cigarette in the room with my child and they have symptoms. They may, but they may not.

Primarily, I take care of children with asthma. And we know that cigarette smoke or exposure to secondhand smoke is an irritant. And the issue with asthma is chronic inflammation of the airways, which, again, sort of like exposure to secondhand smoke, is a difficult topic for parents to grasp, because inflammation in the airways is not something that a parent can see in their child and not necessarily something that the child can feel, but it's where we currently aim our treatment. So we can give the child all the best medications for asthma to treat that inflammation, but if we don't control exposure to triggers or irritants like secondhand smoke, they will not get better.

So what is the result of being continuously exposed to a trigger? One, we may have to give them more medication than they should actually need. And then we're talking about very serious medications like inhale cortico-steroids -- these are medications a child has to take every day. They're expensive, it's difficult to

do when you have a busy schedule. If the child doesn't take the medication, they may be missing school, the parent may be missing work to take them to appointments to the hospital, to the emergency room, and it just goes on and on.

I can tell that you as far as asthma, I know statistics from 1993 that direct and indirect medical costs just for that one year was about $12 billion. So when we're talking about a known trigger of asthma, which is the number-one chronic disease of childhood, I believe it's the number-one reason that children come to the emergency room at Children's Hospital, I believe it's the number-one diagnosis for admission to the hospital. This is a preventable thing. Exposure to secondhand smoke is totally preventable and would make a huge different in the lives of children and not just costs, economic costs, but real-life costs in terms of their quality of life.

So as I'm getting back to, you know, seeing a patient and doing a history and talking to the patients, this is a huge hurdle that we have to spend quite some time discussing with them, and it's very difficult. Every time we see

a patient, we again ask, Is there smoking in the home, who's smoking? And it's just a very difficult topic to deal with. And it just is totally preventable.

I'd be happy to take any questions. Thank you.

COUNCILWOMAN TASCO: Thank you.

Councilman Nutter?

COUNCILMAN NUTTER: Thank you, Madam Chair. Just one quick question for all three, and you could answer in a "yes" or "no" fashion.

Are there any medically safe level of exposure to ETS?

DR. LEONE: Tobacco smoke, whether it's direct or indirect, has a dose effect kind of response. The more you get, the worse it is; the less you get, the better off you are. In addition to that, it really depends on your sort of inherited susceptibility to the effects of tobacco smoke and its constituents.

You really shouldn't consider there to be any acceptable level in terms of parts per million of constituents, primarily because tobacco smoke concentration is not homogeneous throughout

the environment. You know, if you happen to be in the back row of the plane when smoking was allowed, the level of environmental tobacco smoke was much higher than if you happened to be in the front row. But, truthfully, there is no good way to control levels in any one person's environment like that.

Directly, you probably shouldn't consider there to be any safe levels, but the lower the better, obviously.

DR. PIATT: I concur actually. The problems with the studies that we've had so far has actually been able to --

COUNCILMAN NUTTER: Would you pull that microphone a little closer, please.

DR. PIATT: -- characterize the amount of smoke in the environment.

I have to at least agree in terms of the dose of the smoke and the time of exposure, it's been clearly linked, but an absolute level has not clearly been established and probably won't be, just because of the difficulty in performing such a large study that can actually individualize the microenvironment of how much

smoke is in a room. So. . .

MS. WINSTON: Yeah, I would agree. And I just want to bring up that a child who does not have asthma, who is exposed to secondhand smoke but was predetermined to have asthma, that's enough to trigger asthma, where they may have not developed asthma if they were not exposed to smoke.

COUNCILMAN NUTTER: Thank you.

COUNCILWOMAN TASCO: Councilman Rizzo?

COUNCILMAN RIZZO: Thank you, Doctors and the nurse practitioner. A person that is exposed to secondary smoke, that becomes ill, when you have a patient that has not been or at least you believe that has never been exposed to secondary smoke and they come up with the same medical problem, how do you explain that? How do you explain a person that is 90 years old and smokes two packs of Camels a day, and they tell it would kill 'em if they stopped smoking? How do you --

DR. LEONE: Can I take this one?

COUNCILMAN RIZZO: How do you describe that?

DR. LEONE: Councilman, I have a practice where all I do -- about 50 percent of my practice is actually the care of current smokers, and the care I deliver is specifically designed to get people to stop smoking. In that practice, I frequently run across patients who come up to me and say, Well, you know, why the heck should I stop? I have -- my grandmother smoked till she was 90, and she was healthy as a horse.

And the way I try to explain it is a matter of probabilities. There are people who don't smoke who will develop lung cancer, asthma, respiratory infections. There are people who do smoke, who are exposed to environmental tobacco smoke, who will never develop those diseases.

I give them the analogy of a room -- of two rooms filled each with 100 people. And into that room, we're going to spray some chemical, and I spray the chemicals in different ways, different -- there's a different mechanism. And in one room, 3 people will die; and in the other room, 30 people will die. Certainly in both rooms, someone's going to die; and in both rooms, many people will live. However, which room would you

rather be in? I would personally rather be in the room where only three people will die. That doesn't guarantee that I'm going to make it out alive, but I have a lot better chance.

It's the same thing with environmental tobacco smoke, it's the same thing with primary smoking. Neither of those exposures guarantees that you will get disease or not get disease, but your chances are modified dramatically, tenfold or more, for certain diseases.

COUNCILMAN RIZZO: Doctor, have you been able medically to determine why that young child contracts that same ailment and is never exposed to secondary smoke?

DR. LEONE: Sure. It's -- the easiest way to answer your question is actually to use the example of lung cancer, rather than in children, because -- only because it's in more obvious and we have more information about lung cancer. So if I might take a little liberty to answer your question a little indirectly.

In the case of lung cancer, people have always gotten lung cancer. Prior to the early 20th century, lung cancer was on exceptionally

rare disease. The old axiom was, if you were in medical school and you happened to get a cadaver that had a lung nodule in it, you'd call all your classmates over because you were never going to see that again in your life.

Today, people are still getting lung cancer, they're getting it much more frequently. The reason they get cancer more frequently now is obviously because of primary smoking, environmental tobacco smoke, but they still got lung cancer back before cigarettes were so ubiquitous because cancer, as a disease, is really the end-product of injury to cells inside the lung. In the past, really the only mechanisms we had to injure those cells were really the environment, perhaps radon, perhaps some modest elements of pollution; now the primary mechanism that we have to injure the lung is cigarette-smoking.

In children who don't smoke who get asthma, the primary mechanisms that cause inflammation really are, to some degree, environmental. Some of them are avoidable, some of them aren't. But today, the reason why so many

young children develop asthma and respiratory symptoms really has to do with the ubiquity, the complete availability of environmental tobacco smoke; yet injury to the lungs is really the final common denominator.

COUNCILMAN RIZZO: Thank you. That was a good way to describe that. Thank you.

DR. LEONE: Thank you.

COUNCILMAN RIZZO: Thank you, Madam Chair.

COUNCILWOMAN TASCO: Councilman Ortiz?

(Councilman Ortiz away from desk at this time.)

COUNCILMAN ORTIZ: I'll be right there.

COUNCILWOMAN TASCO: Councilwoman Brown?

COUNCILWOMAN BROWN: Good afternoon.

When you service parents at Children's Hospital whose children are suffering the consequence of their conduct, what do you have in the way of education? And hopefully -- I don't know if prevention is -- works at that time at that juncture, but what do you have in the way of

education that hopefully moves them to reckoning with the fact that their conduct is indeed impacting on the health of their children?

MS. WINSTON: Well, as I said, it's something that we discuss initially when we see patients and it's an ongoing process of counseling every time we see the parent with the patient. And we can show them -- if a child is old enough, we do lung-function testing and we can document what medications they are using. We quantify their symptoms and how much school is missed and how many ER visits, hospitalizations they have. And we can say to the parent, We've done everything, your child's on the maximum treatment. This is something that's going to increase their inflammation and increase their symptoms.

What we do is we refer them to programs, we ask that parents contact their insurance or HMO -- many of them have smoking cessation programs -- or we refer the parents back to their primary physician for help for themselves to quit smoking.

But, again, what I do is counseling, and I try to be supportive. You may have quit in

the past, you'll quit again, and you'll do it when you're ready. And it's ongoing, it just never ends.

COUNCILWOMAN BROWN: This may not be your role and/or you may not have the resources required to conduct the follow-up to see how successful counseling the counseling is that moves them towards the elimination of that habit. Anything like that? Do you have anything that tells you how successful you are?

MS. WINSTON: No. It would just be supporting them, continuing to address the issue, and referring them to their primary physician, their insurance, or to the American Lung Association for programs that know how to do it. Because if you speak to people who do run smoking cessation programs, unfortunately, I don't think -- I don't know if you work with a program, but the success rates are -- it's not that great. The reason that I'm so careful how I work with parents is because it is really a difficult thing, to quit smoking when you're addicted.

DR. PIATT: Among our own patients that I see in my practice of successful smoking

cessation, at least in an adult population, is still fairly poor in terms of achieving success. In my clinical practice, about 20 percent of people that receive optimal -- absolute optimal care, including counseling, smoking cessation aids, nicotine patches, still can't achieve smoking abstinence.

So it's not something that's achieved easily, but just on our parts, we really try as aggressively as we can with our patients because we know the risks are so high.

DR. LEONE: If I might. I realize the question was directed here, but I might like to add something. This is really my own personal thing.

One of the reasons that I went into the business of smoking cessation was because all around me was all this dire lung disease and things were terrible, and I really -- I could shake my finger at patients and I could say, "You really have to stop smoking," and it wouldn't happen. Quitting smoking is an incredibly difficult thing for people to do. It fundamentally motivates people's behavior in ways

that they really don't understand, and they spend a lot of time in life feeling guilty about why they're doing what they're doing.

A couple of years ago, the Agency for Health Care Policy Research came out with a set of guidelines to help clinicians help patients quit smoking. And, in fact, all across the board, the numbers for cessation have been increasing, I think, because primarily of sort of a concerted effort. Physicians like Clark get back to work and they kind of put all the tools in place and they help people quit smoking at a higher rate than we've ever really been able to help people before.

We have a series of patients at the Center where, by putting all the tools in place, we've been able to actually get 55 percent of the patients that come through the door to quit smoking. The point of that is that one of the reasons that we are a little bit afraid of environmental tobacco smoke as an issue is because there are so many people out there who are smoking who fundamentally believe that it is their God-given right to smoke. And the reason they

believe that is because inherently, underneath all of that, they are terrified, abjectly terrified of the notion of quitting smoking. For many, many smokers, smoking is as fundamental an activity as breathing every day, and the notion of giving it up is untenable.

And so I would suggest that some of the influence that you will feel, modifying what you know about ETS, comes from smokers, smoking advocacy groups, because traditionally, we've really not had the tools to help those people quit. As we continue to develop those tools, I think the issue of environmental tobacco smoke will become an easier one and sort of a more self-evident one five or ten years from now.

COUNCILMAN ORTIZ: I just have one question.

In terms of potential cost to the a city the size of Philadelphia -- maybe Estelle might have a better answer because she is into it; you may not have the total answer. But in terms of costs to the City of Philadelphia, in terms of its health system, in terms of what the taxpayers have to bear for the people who then go to the

hospitals' emergency rooms and have to be taken care of, do we have any sort of figures, data on that sort of situation of ETS? Because I think we have something on direct smoking of tobacco, but do we have anything on ETS, and what is that?

DR. PIATT: At least in the California studies, where we've really had the best chance to look at smoking cessation within restaurant and bars and the like, there's clear data to show that at least days of work is better, people are able to at least not miss work. In addition, health-care costs were decreased in terms of medical visits.

In terms of the absolute numbers, it's something that's not been able to at least be put together by these studies, but we just infer by the amount of people that are directly exposed --

COUNCILMAN ORTIZ: Is there approximate numbers that are there, given the California situation, that can be extrapolated and perhaps compared to a city such as Philadelphia?

DR. PIATT: I know of nothing, at least from the data from California. And, Dr. Leone, do you know of any specifics?

DR. LEONE: Offhand, Councilman, I don't have that information, but I'm happy to try and extrapolate those numbers for you.

COUNCILMAN ORTIZ: Can you please?

DR. LEONE: I --

COUNCILMAN ORTIZ: Those of us who deal with this, and in terms of the City of Philadelphia, it comes down later on to the numbers in terms of expenditures of taxpayers' money to be able to take care of those individuals that cannot take care of themselves, that do not have insurance down the line. So those numbers would be important to us.

DR. PIATT: I think that there may be one referenced article that may have some at least approximate numbers that I could forward to the office for you.

COUNCILMAN ORTIZ: Okay.

COUNCILWOMAN TASCO: Thank you very much. Thank you very much for your testimony.

DR. PIATT: Thank you.

DR. LEONE: Thank you.

MS. WINSTON: Thank you.

COUNCILWOMAN TASCO: You may be coming

back when we do our tobacco bill.

Next, we'll have Estelle Richman, Director of Social Services, City of Philadelphia.

(Witnesses come forward.)

MS. RICHMAN: Good afternoon. I am Estelle Richman, Director of Social Services for the City of Philadelphia. I have with me today John Domzalski, the Acting Commissioner of Public Health, Darlene Messina, who is the Project Manager for Smoking Cessation for the Department of Public Health.

I am pleased to present testimony on the issue of secondhand smoke, which is of major public health concern in Philadelphia. Mayor John Street has declared the year 2000 "The Year of the Child," so I would like to begin my remarks by talking about the effects of secondhand smoke on Philadelphia's children.

I will then speak briefly about approaches to control the situation in Philadelphia and summarize some findings of recent Health Department studies about maternal smoking and its effect on women and their children.

Finally, I will touch upon the City's

participation in the tobacco settlement discussions that are now occurring in Harrisburg.

As many as 12 million American children under the age of 5 are smokers. They may never pick up a cigarette, but they are smokers just the same. They live in homes with at least one smoker, and their developing lungs may be permanently scarred by the exposure.

Passive spoking, sometimes called "involuntary smoking," happens when someone breathes the mixture of smoke given off by the burning end of tobacco products, called "sidestream smoke," and smoke exhaled by smokers, called "secondhand smoke." This mixture makes up environmental smoke.

Environmental tobacco smoke contains about 4,000 substances, more than 40 of which are known to cause cancer in humans, such as benzine, nickel, and formaldehyde. Other chemicals present in tobacco smoke, such as carbon monoxide, nitrogen oxides, ammonia, and hydrogen cyanide, are strong irritants that can cause a variety of serious cardiac and pulmonary diseases.

Because their lungs are still

developing, infants and children are generally more susceptible to disease brought on by exposure to air pollutants than all otherwise healthy groups in the population, with the possible exception of the elderly. According to the Environmental Protection Agency, prenatal and early postnatal passive smoking literally alters the structural and functional properties of the lung, thereby increasing the likelihood of severe complications to viral respiratory infections contracted early in life.

This is what secondhand smoke does to children. It is estimated that 4 million times a year, children are brought to the doctor with infections or symptoms, including coughing and wheezing, that are a result of exposure to secondhand cigarette smoke. The smoke irritates the lungs and compromises the immune system, opening the way for more viral infections. Children who are exposed to secondhand smoke often suffer from bronchitis, pneumonia, and viral infections. The more smoke they're exposed to, the greater the number of infections.

The Environmental Protection Agency

estimates that environmental tobacco smoke is responsible for between 150,000 and 300,000 lower-respiratory tract infections in infants and children under 18 months of age annually, resulting in between 700 and 15,000 hospitalizations each year.

According to the Surgeon General, children regularly exposed to secondhand smoke have a reduced lung capacity and have a harder time fighting off lung infections. The problems can begin before birth and may continue at least until young adulthood.

Some children exposed to secondhand smoke never achieve full lung capacity. Nationally, infants whose mothers smoke are two to three times more likely to die of Sudden Infant Death Syndrome, SIDS. In addition, an estimated 700 SIDS deaths each year are brought on by lung problems caused by secondhand smoke.

Up to 26,000 new cases of asthma per year may be caused by children's exposure to smoke. When their parents smoke, children are almost twice as likely to get asthma. For children who already have asthma, a smoking parent

makes asthma attacks much more frequent and more severe. The number of visits to the emergency room is 50 percent higher for asthmatic children with a smoking parent.

Mothers who smoke during their pregnancy are more likely to deliver low birth weight infants who are at greater risk of being born prematurely and needing special care.

That's some of what we know in general about the insidious impact of secondhand smoke. In Philadelphia, the data painted an even more troubling picture.

According to a 1998-1999 household survey conducted by the Philadelphia Management Corporation, over a quarter of Philadelphian adults smoke, about 28.6 percent. The state average is 23.8 percent.

Philadelphians have a higher rate of lung cancer compared to Pennsylvania figures. For men, 115 cases per 100,000 have a form of lung cancer, compared to 84 cases per 100,000 in the state. Women also have a high rate of lung cancer compared to the state rate -- 59 cases per 100,000 compared to 41 cases per 100,000.

There is an asthma epidemic nationwide, and Philadelphia is no exception. Almost 10 percent of all Philadelphia residents report having asthma, versus a 5.4 percent rate nationwide. In our city, this includes 10.4 percent of children 17 years and under. Surveys show the highest rates among African-Americans and Latinos as well as significantly higher rates among persons below the poverty level. Trends from 1982 to 1998 show an increase in each of these measures.

According to a recent clinical study by the Health Department's Division of Early Childhood, Youth and Women's Health, pregnant women in Philadelphia smoke in greater numbers than they do nationally. Current national research reports that 25 to 40 percent of low-income pregnant women smoke. But after we collected and analyzed urine samples from pregnant women seen in our health-care centers, we found their exposure was much higher -- between 50 and 60 percent.

With this in mind, it is not surprising that Philadelphia also have disproportionately

high rates of pre-term birth and low birth rate. The carcinogens of tobacco are harming Philadelphia's younger citizens even before they're born. And remember, all this smoking also affects other adults and children in the household.

A second Health Department study told us something about nonsmokers' exposure to tobacco smoke. Again, by testing women's urine in the prenatal clinic, we found that many nonsmoking pregnant women, along with their unborn infants, are exposed to a high concentration of tobacco smoke, an exposure equal to that of a moderate smoker. This is because they live or work with smokers. This level the exposure is significant and increases risks for pregnancy complications and poor birth outcomes.

Several steps have been taken in the City to control smoking and exposure to environmental tobacco smoke. Two City ordinances restrict youth access to tobacco: Bill No. 940097 prohibits and enforces the sales of tobacco products to minors and requires identification as proof of lawful age; Bill No. 960367-A further

restricts the access of youth to tobacco products sold in vending machines. These were enacted in 1996 and 1998.

Former Mayor Rendell issued Executive Order No. 12-93, which prohibits smoking in all City-owned and -occupied space to which the public has access. In addition, many local businesses have become smoke-free of their own volition.

However, much more needs to be done, especially to address the exposure to the most vulnerable among us, our children. This will require both effort and money. It is very timely that you hear and understand these issues presented before you today, as budget allocations for the Pennsylvania tobacco settlement monies are being negotiated at the state level. The City of Philadelphia should advocate for its share of these dollars for intervention and prevention programs as well as for research and public health campaigns to produce the disproportionate health, economic, and productivity costs due to smoking and secondhand smoke.

I would be glad to answer any questions for you and have my colleagues who are with me

answer the more specific questions. Thank you very much.

COUNCILWOMAN TASCO: Thank you very much. I see that you have a packet here, Miss Messina, about the City's program. Could you just briefly describe that briefly.

MS. MESSINA: Sure. I'm Darlene Messina. I manage the Smoking Cessation Initiatives in the Division of Early Childhood, Youth and Women's Health.

What you have in front of you is a number of materials that we make available to the clinics. Specifically, we're trying to address the issue of environmental tobacco smoke. What you heard from Estelle was that we found out that there are women living in households with a number of smokers, and they have high concentrations of cotinine within their blood stream, which is a metabolite of nicotine. This is really shocking, both to the women who hadn't known that -- they knew that they were exposed but not to such a high level.

So the issue of secondhand smoke is an important one, one which I don't think we've paid

enough attention to. So what you have here is information, which we make available to the public health clinics and the clinicians to use with women seen at the clinics.

What we're hoping to do, and I think you've heard some testimony earlier, is that it's very difficult to break the addiction. It's a chemical addiction, nicotine is a drug. And just to say to someone, "You shouldn't smoke, it's not good for you," you know, "Smoke out of the house," and expect people to make these kinds of changes is somewhat of a hefty goal for a number of these people. So what we're asking them to do is to take a step-by-step approach to first making their homes smoke-free, and it's a step-by-step initiative that we're hoping to implement.

One of the things we do need, and I'm going to advocate for this, is more funds for programs. I am the only person in the City of Philadelphia's Health Department trying to roll out a number of programs. You know, you could -- public health campaigns are very important, but we need to reach the people in the clinics that, you know, present themselves with high levels of

exposure.

And I'll answer any other questions.

COUNCILMAN NUTTER: Thank you. First, Director Richman and Darlene Messina and John Domzalski, good seeing you this afternoon. Let me stay on the cessation, and then I'd like to go back to the Director.

We have had situations in the past where, working in conjunction with the Administration and with the Department, based on what you've laid out in terms of what you are able to provide in the clinics today, would you provide to the Chair, after a chance maybe to go back with the Director and others, maybe three levels of program or approach, that if you have X-amount of dollars, you would be able to provide this level of service; if you had another level, that amount of service; and if you had another level, that amount of service.

And give us in the Council, I guess, some sense of what you'd be able to do with different levels of funding and, I mean, if you could lay that out programmatically.

MS. MESSINA: Sure. I had anticipated

this and --

COUNCILMAN NUTTER: Director Richman has been around for a while and she knows the drill.

MS. MESSINA: There are many layers in which we would probably approach the situation, and I'm going to read a list of program initiatives that are either unfunded or underfunded. Number one --

COUNCILMAN NUTTER: And before you do that, could you also -- my other question about this was -- and I understand now from your testimony that this is primarily through the health clinics that you're doing this work?

MS. MESSINA: Yes. Intervention is in the health clinics.

COUNCILMAN NUTTER: And do any of these programs impact City employees? Or, I mean, do we have a separate program for City employees who are trying to deal with this same issue?

MS. RICHMAN: We have tried, and we had within the previous administration several programs where we've tried to impact City employees through our health promotion activity,

where we actually made available to City employees patches, physical exams, smoking cessation, clinics, and actually ran them for any department or any employees who wanted to partake of that.

COUNCILMAN NUTTER: Okay.

MS. RICHMAN: And we did that probably over the course of a couple of years. I don't think that we've intensified it, although many of the materials and the opportunities continue to remain available for City employees. If they would want to do it, the Health Department is willing to go out and work with any other department that sees that as an issue.

I wish I had in front of me the departments that did take us up on that, but there were several departments that we specifically worked with around smoking cessation.

COUNCILMAN NUTTER: Okay. Maybe you could provide that to us later.

MS. RICHMAN: We will.

COUNCILMAN NUTTER: Okay.

MS. RICHMAN: What Miss Messina had given us is a list of -- if we were to get our share, or a fair share, of the tobacco money --

ways that we would be able to spend that money, that would help us with many of these issues. We can make this available to you.

What these are at this point are concepts of how we would spend the money. There are not dollars attached to it, but if you wanted us to give you a ballpark figure on what some of the costs of these that might occur, I'm sure we could do that also.

COUNCILMAN NUTTER: That would be helpful.

MS. RICHMAN: But there is a list of ten different activities that could be implemented here in Philadelphia, or initiatives that can be done that would substantially help us fight this problem.

COUNCILMAN NUTTER: Go ahead.

MS. RICHMAN: Okay.

COUNCILMAN NUTTER: Do you want to read them into the record?

MS. RICHMAN: Sure, we'll read them into the record.

MS. MESSINA: Okay. We would want to implement citywide a clinically-delivered

intervention programs in adult health, prenatal and pediatric clinics, so all interventions would be sort of standard care. And one thing the Agency for Health Care Policy and Research -- I think they've done a pretty extensive survey and research in the area of interventions compared to community-based and clinically-based.

Clinical-based interventions proved to be more successful. That's not to say that you shouldn't have community-based smoking cessation programs in, let's say, rec centers or churches. Those are all -- they should happen and they should be supported. But smoking is a behavioral and chemical addiction, and it should be addressed clinically as well as community programs. So we would want to implement citywide a protocol and a standard of care in adult health, prenatal, and pediatric clinics. And the pediatric clinics is to address the adult smoker in the household.

We'd like to fund local research to determine the efficacy of innovative and cost-effective, clinically-delivered smoking cessation and reduction programs. And I want to just briefly tell you about the small studies we

conducted in Philadelphia.

There's a tool recently available called the "nicometer," and it's like some of these other prenatal tools that they use to sample women's urine for diabetes and high sugar counts. And you dip it in the urine, and it immediately gives you the level of nicotine exposure. And what we were hoping to do was that after the woman would come -- during her prenatal clinic, she gets her blood pressure checked, her weight, and a lot of other information she receives about her pregnancy. She would also get feedback about the level of exposure.

And I think -- we pilot-tested this in a number of clinics and we asked the women what they thought about this feedback. And, actually, the women who did participate in the study thought it was very helpful to them -- not only the nonsmokers 'cause they really didn't really believe they had exposure.

But even the women who were smokers, they didn't -- it's kind of like a denial. You can tell them that it's in their urine, they can see it on the stick. It helps them to realize

it's a bigger health issue for them and their children.

So this is an innovative study. It is currently underfunded. You know, it would take a lot of money to actually roll out this study in a more comprehensive way. So we need money for research.

We would want to fund citywide outreach programs to reduce environmental tobacco smoke in the homes. And this would be a home visiting program. There are a number of home visiting programs right now that visit households for lead and follow-up care for the baby who comes home after being born. And we would like to also include a piece about secondhand smoke. Right now, that's not currently funded.

Community-based smoking prevention and cessation programs. Like I said, that still needs to continue to happen. You know, it's -- it can be effective but, you know, it needs to be there anyway.

We'd like to provide technical assistance and professional education for health professionals. That is training of all clinical

professionals in the clinics. Their skill level needs to be increased in addressing tobacco addiction.

We'd like to have a citywide anti-smoking, smoke-free family public health campaign, using SEPTA, TV ads, radio, you know, a comprehensive campaign -- underfunded, barely funded right now.

Surveillance and data collection, which we need to understand our population. We would need money to fund that.

Development, purchasing and distribution of educational materials -- currently underfunded. We'd need additional staff to do this.

And the implementation and management of an 800-number locally to help people address the issue of addiction and environmental tobacco smoke.

Thank you.

COUNCILMAN NUTTER: Well, all of these items would be a part of the -- kind of the Program A, Program, B Program C data request that I had made earlier, right?

MS. MESSINA: Yes.

COUNCILMAN NUTTER: And you'll get that to the Chair.

MS. RICHMAN: Yes.

COUNCILMAN NUTTER: One last question for Director Richman. Much has been put on the record about the impact on not-yet-born infants, toddlers, adolescents, a lot of young people, and the impact of ETS, and there has been discussion about adults.

Just for a moment, what would you say to, I guess, the argument that, Well, we understand that there's an impact on kids, and if we just make sure that kids are not in the places where there is smoking going on, that that would basically kind of solve the problem notwithstanding the fact that some of these adults in the places where smoking is going on go back either home or to work or go wherever they go, and there are young people or others around. And what is the real impact on adults of all this?

MS. RICHMAN: To stay a little bit with some of the children's issues, the adults take care of the children. You have to have the adults

in the children's lives, you have to have adults doing the work. Everyone in this room essentially is an adult. We need the adult, and it affects their quality of life also, and it's a significant cost.

One of the issue that the tobacco lawsuit brought out is the number -- the cost of health care for people who -- for adults who have lung cancer. It is a primary public health issue in compromised health care, whether it's emphysema, whether it is cancer. Whether it's any other type of respiratory problem, it is a quality-of-life issue, it has a financial issue on the family, and it has financial issue for the hospitals and the clinics.

So the -- while we can -- I think, in part, the child issue is a critical one and it's a good way to get everybody's sympathy, but it's the adult issue that actually got it into the attention of the media and the district attorney in the State of Washington that began to see the impact of Medicaid and the impact of public health -- on hospitals and the impact of caring for people with compromised health, the adults with

compromised health in our society.

So while, indeed, I think we've presented the child's side of it, the reality of it is that it's the adult side of it that is tending to drive most of this, which is the -- in many ways, the cost to the Medicaid program on a federal level, and the adults who wish they didn't smoke and who would have quit if they could and who've recognized the addiction part of smoking as a compromise to their quality of life.

COUNCILMAN NUTTER: Okay, thank you.

Thank you, Madam Chair.

COUNCILWOMAN TASCO: Any other questions?

Councilwoman Brown?

COUNCILWOMAN BROWN: Good afternoon.

MS. RICHMAN: Good afternoon.

COUNCILWOMAN BROWN: A comment and one question. I will use this time now to formally register that we will invite you back to speak at the pubic hearings that will deal with the resolution around what should happen with regards to the tobacco settlement, so anticipate that sometime in the next 30 days.

In your list of recommendations on how the dollars can or should be spent, there was no mention of Philadelphia public schools as one area, and though you've made it clear that it is really a clinical issue, there is some value in informing, educating young people, children early that long-term, you need to stay away from this.

So is there any connection, relationship, potential dialogue with the public school?

MS. MESSINA: Well, actually, we have a very formal and informal relationship with TEACH. We're one of the partners, and their focus really is on youth prevention and intervention. So I would defer to TEACH, and they will be testifying, I hope, right after we do.

COUNCILWOMAN BROWN: Oh, okay.

MS. MESSINA: So I have to apologize if they're not listed in terms of our focus for the Department of Health. You know, we work in conjunction with them. As I said, I'm one person out there, and my focus has been pretty much with prenatal and maternal issues and infant and child issues. So TEACH is really the advocate for the

tobacco control and intervention for youth.

COUNCILWOMAN BROWN: Very well. Thank you.

MS. MESSINA: You're welcome.

COUNCILWOMAN TASCO: Any more questions?

(No further questions.)

COUNCILWOMAN TASCO: Thank you very much.

MS. RICHMAN: Thank you.

COUNCILWOMAN TASCO: Our next panel will consist of Dr. Edward Emmett and Attorney Joseph Minott, who will talk about the adverse health effects of exposure in the workplace and in other public places.

(Witnesses come forward.)

MR. EMMETT: Madam Chair and Members of Council, I'm Dr. Edward Emmett, and my background is, I'm a physician, not a Ph.D. as in the program, and I'm trained in occupational and environmental medicine, preventive medicine, and toxicology. And I was the professor and director of the Center of Occupational and Environmental Health, Johns Hopkins, for ten years.

And then I went back to Australia, and I headed the federal agency that had the equivalent functions of OSHA and EPA; and in fact, there we developed standards for passive smoking at the workplace. And now I'm professor at the University of Pennsylvania.

And you've heard a lot of testimony, and I don't intend to reiterate that, but I'd like to concentrate on three aspects: firstly, the effect of environmental tobacco smoke on susceptible individuals in the workplace; secondly, the widespread nature and relatively high levels of ETS that are associated with occupations, and particularly the very high levels in some groups of workers such as bar, restaurant, and casino workers; and, thirdly, the effectiveness of bans, not only in reducing environmental tobacco smoke levels at that site, but in producing better quit rates.

With respect to the effective environmental tobacco smoke on susceptible individuals, a common clinical problem I face as a specialist in occupational and environmental disease are the patients who are intolerant of

secondhand tobacco smoke at their workplaces. And usually these people are intolerant to a number of things -- tobacco smoke, strong cleaning agents, diesel exhaust, even strong perfumes. And it is an increasing problem. This is much of the basis of what is now known as "sick-building syndrome," of things like multiple chemical sensitivity. And in all of these conditions, sensitivity to environmental tobacco smoke is very important.

There are a number of symptoms that can be made worse: sinusitis, headaches, rhinitis, runny nose, reactive airways (people get wheezing), and asthma. The basis of this intolerance seems to be inflammation in the airways, and it's not present all the time necessarily. It's worse after bronchitis, it's worse if people have allergic reactions. And we can see and study changes in lung-function tests in these people.

These sort of intolerances are not seen in normal people, but in my work, I see a lot of people with them, and I think there's a lot of people in society with them. The question was raised earlier about safe levels. I don't believe

for these people there are safe levels of environmental tobacco smoke.

The second thing I'd like to comment on is the quite significant levels of environmental tobacco exposure that's associated with work. A surprisingly large number of Americans are exposed to environmental tobacco smoke. Earlier, people talked about measuring cotinine, a substance in the urine that comes from nicotine. Eighty-eight percent of all Americans have cotinine in their urine to show that they've been exposed to environmental tobacco smoke. More than half of that is probably associated with work exposures, and we can certainly see that the hours of exposure to tobacco at work, as they increase, the amount of chemical in the urine increases from smoke.

Now, the levels of environmental tobacco smoke where you work vary a lot, depending on a lot of factors -- how much ventilation, how big the room is, how many people are smoking. But there are a number of observations we can make because we have -- a lot of studies have been done.

Firstly, in offices, the levels are something like the levels that are seen in homes, maybe a little lower.

Secondly, in restaurants, levels are about one and a half times those in the homes where one or more people are smoking. And in bars, the levels are from four to five times the levels seen in homes where people are passively smoking.

Studies of lung cancers in bartenders and in restaurant workers show that these people have elevated lung cancer levels -- about a 50 percent increase on what they would otherwise have, after we adjust for the active smoking that's done. So these people appear to be truly at significant risk because of the passive smoking there.

It's rather difficult, and one of the experiences I had in Australia was the difficulty in dealing with smoking in places like casinos, restaurants, and bars. And just to digress, I think this is not the case in Pennsylvania, but in Australia, the casino business, which is very profitable, depended on people coming from the

Asian countries -- Indonesia, Hong Kong, Singapore -- who would come to the casinos. And there was one characteristics of high rollers -- they were chain smokers. And it's a very difficult economic issue to deal with parts of economy that are heavily dependent on people who are chain smokers, and yet, we were putting the casino workers at considerable risk there.

I'm impressed now that the types of jobs we're looking at increasing in cities to give employment are often jobs in the entertainment, the restaurant, the casino types of businesses, and those are the very people we are putting at risk of environmental tobacco smoke if we don't also act to control those exposures.

And that brings me to the third point I'd like to raise, and that is the effectiveness of bans and non-smocking policies. The protection afforded nonsmokers is being well evaluated, particularly in California as part of the California tobacco surveys. And in California, people who worked were surveyed to see where the smoking bans at their workplace had any effect on exposure to smoke -- and the answer was, it did.

Where there was no workplace smoking ban in place, more than 50 percent of the people said people had smoked in their workplaces within the last two weeks. Where there was a smoking ban that wasn't in the area where that person worked, 47 percent of people had been exposed at work. It really hadn't made much difference unless the ban was in their area. But where there was a smoke-free workplace as a whole, only 9 percent of the people had been exposed to environmental tobacco smoking the last time. So the bans were effective in reducing exposure.

But the other thing that may be more impressive is that workplace smoking bans increased the quit rates for smokers who work in those areas. In response to questions that were asked earlier, there was comment about the difficulty, and it really is a difficulty, the difficulty of stopping people who smoke, because it is a true and a strong addiction.

There's been a study of workplaces where -- and all in hospitals, similar hospitals, a very well designed study -- taking people who worked in hospitals where there was a smoking ban

and comparing them with the people who work in hospitals where there wasn't a smoking ban. At the end of one year, 6.6 percent of the employees had quit where there was a smoking ban versus 3.3 percent of people in other places. But more impressive was, as time went on, more people were able to quit where there was a smoking ban. And in this study, 51 percent of the hospital workers in hospitals where there was a smoking ban had quit after 5 years versus 38 percent in the comparison hospitals where there wasn't a ban.

So the more you have a smoking ban at work, the easier it is for someone to give up smoking. And that, of course, has the additional public health benefit that those people who stopped smoking will not smoke now at home, they will not smoke in their vehicles, they will not smoke in their recreational areas where they take recreation. So that that is then reducing the whole community's exposure to smoke, including the unborn, the children, and other family members.

So bans are very effective and have an effect beyond the workplace where they're instituted.

Thank you.

COUNCILWOMAN TASCO: Mr. Minott?

MR. MINOTT: Thank you very much. My name is Joseph Minott. I am an attorney and environmentalist, a soccer coach, and a community activist. I am a full-time Executive Director of the Clean Air Council, which is headquartered in Philadelphia.

But my most important role is that of a father. My son, Christopher, is an active 10-year-old. He loves to play soccer and basketball. He is also an asthmatic. I do not know how many of you in this room today have had to deal with a child that has had to be rushed to the hospital because he could not breathe, or even had to explain to a child that he needs to skip a soccer game because air pollution, indoors or outdoors, is making him wheeze. If you have an asthmatic member of your family, you will understand the urgency I feel in this topic.

The Clean Air Council is a membership-based nonprofit organization that was formed in 1967 as an affiliate of the American Lung Association to address disease prevention through

a regional approach to air pollution. Please keep in mind as you consider the testimony of the many learned witnesses who you've heard from today a number of facts.

Fact 1: Most people do not smoke. So protection of nonsmokers from secondhand smoke benefits of majority.

Fact 2: Indoor air pollution is a major public health issue. Cigarette smoke increases the threat from other indoor air pollutants.

Fact 3: Asthma in Philadelphia is rising most rapidly in preschool-aged children.

Fact 4: The Clean Air Council gets more calls on the issue of secondhand smoke than any other air-pollution issue.

Fact 5: Cigarette smokers inhale and exhale mainstream smoke 8 or 9 times with each cigarette, for a total of 24 seconds, but the cigarette burns for total of 12 minutes and pollutes the air continuously with sidestream smoke.

Fact 6: The health impact of smoking cigarettes and being exposed to secondhand smoke

are well established.

Air pollution, whether outside or indoors, is dangerous for all of us. It is an even more serious problem for children, the elderly, and people with pre-existing respiratory diseases. The group that health professionals are most concerned about are children with asthma. Asthma rates among children are up 75 percent since 1980, with 4.6 million children suffering from asthma.

In 1998, Pennsylvania had 616 recorded exceedences of the 8-hour federal health standard for ozone smog. Most Pennsylvanians are still regularly exposed to unhealthful levels of ozone. In Philadelphia itself, Philadelphia County, had 27 such exceedences. According to a report recently released by a national environmental organization, each summer in Philadelphia, smog sends an estimated 1600 people to the hospital, 4600 to the emergency room, and triggers 200,000 asthma attacks.

If any of these people also have to deal with indoor air pollution and secondhand smoke, it puts them at much greater risk. For the

elderly and people with chronic respiratory disease, the indoors offers the only safe sanctuary. Clearly, it is unfair to expect people with chronic respiratory disease to choose between outdoor smog and indoor smoke.

The Clean Air Council is well established as the regional expert on indoor air pollution. The Council operates the region's only indoor air pollution information center. Since its inception in 1987, the Clean Air Council has handled more than 20,000 calls from citizens facing a serious indoor air pollution issue. We handle roughly now 2000 calls a year. Since neither state nor federal agencies are mandated to address the indoor air pollution, including secondhand smoke, government agencies refer inquiries to the Clean Air Council.

National trends show that children are spending more time indoors than ever before and, therefore, suffer more from the impacts of indoor air pollution. In Philadelphia, the percentage of children with asthma is rising most rapidly in preschool-age children. Investigation into the origins of asthma, including genetic environmental

causes, shows that poor outdoor air quality, along with other common asthma triggers such as indoor air pollution, increases the number and severity of asthma cases presenting in local hospitals.

Indoor air pollution is a growing health threat in the United States. Air pollution can no longer be thought of as only an outdoor problem. Many indoor air pollutants occur naturally, such as radon, molds, and mildews, but others are generated by people, such as cigarette smoke and cleaning agents.

Over the last 25 years, modern construction techniques, energy conservation, and weatherization have sealed buildings to the extent that ventilation rates are often seriously reduced. Under such circumstances, indoor air pollutants can build to health-threatening levels. The United States EPA has established an indoor air quality as a major public environmental health threat. Secondhand smoke is one source of indoor air pollution that can greatly exacerbate air quality problems.

During the last decade, hundreds of published reports have documented the damaging

effects of indoor air pollution, such as cigarette smoke, to human health, including bronchial constriction, reduced lung function, respiratory illness, and asthma. As a result of pollution found indoors, serious medical problems are affecting the groups most sensitive to pollution, including infants, children, pregnant women, the elderly, and those with heart, lung, or vascular disease.

It is well-established that secondhand smoke substantially increases health risks from common indoor air pollutants such as radon, asbestos, particulates, and volatile organic compounds. That is, these indoor air pollutants in and of themselves are a threat to health, but if you mix it with cigarette smoke, there's a synergistic effect that makes them much, much, much more dangerous.

What I hope you truly hear from health experts and worried parents such as myself is that nonsmokers, especially asthmatics and children, need increased protection from secondhand smoke. City Council's willingness to examine the health impacts is an excellent beginning. It is my hope

that this is the start of a process to address the health, financial, and emotional costs of forced exposure to secondhand smoke.

Thank you very much.

COUNCILWOMAN TASCO: Thank you very much.

Any questions?

(No questions.)

COUNCILWOMAN TASCO: Thank you very much for your testimony.

MR. MINOTT: Thank you very much for inviting us.

COUNCILWOMAN TASCO: The Chair recognizes Mary Tracy and Rachael Millenbach.

(Witnesses come forward.)

MS. TRACY: Good afternoon. My name is Mary Tracy. And I work for the Health Promotion Council of Southeastern Pennsylvania.

The Health Promotion Council is a nonprofit corporation organized in 1981, with the mission to promote health and prevent disease, especially among those at greatest risk, through education, outreach, and advocacy. Our Tobacco Control and Prevention Program works on many

fronts, including education and prevention, smoking cessation, elimination of easy availability of cigarettes to minors, and a voluntary smoke-free restaurant campaign.

The Health Promotion Council is part of a five-county coalition known as "TEACH," Tobacco-free Education and Action Coalition for Health. TEACH members work to encourage our community to make intelligent and healthy choices about tobacco.

One of the major accomplishments of the Health Promotion Council's TEACH Coalition was the passage of two laws here in Philadelphia which addressed youth access to tobacco products by holding merchants accountable for the illegal tobacco sales to minors. The laws required that all tobacco be placed behind counter or in a locked case, and that merchants ask for photo I.D. for anyone who appears to be under 25 years of age.

After the passage of the laws, TEACH took on a major community-wide mobilization campaign to ensure enforcement of the law. As a result of our efforts, the rate of tobacco sales

to Philadelphia youth dropped from a high of 85 percent in 1994 to the most recent survey of; 43 percent citywide.

The comprehensive campaign to bring merchants into compliance with the law includes a toll-free community hotline, media coverage, and the issuance of $100 fines to violators. Hundreds of concerned parents and community members now call in to report stores in their neighborhoods for selling tobacco, and the City has collected over $110,000 in fines for violation of this law.

I've included this in the preliminary part of my testimony because I think it's important for City Council to realize how important laws are in effecting social change. And it's no secret to anyone in this country, after the tobacco hearings so ably identified all the problems that we have with tobacco. And I think as public health advocates and elected officials, it becomes our duty really to look at the facts and to make some efforts at changing the culture of tobacco in our society.

The Health Promotion Council strongly supports a public health policy aimed at

protecting the rights of all workers to breathe clean air. Our staff and student-interns recently collected information on Philadelphia businesses and office buildings. We wanted to learn about current smoking policies.

I know all of us have passed through the corridors of Broad Street other main roads and have seen the clusters of smokers outside buildings, and I -- although I'm in the tobacco business, I didn't really know that much about what secondhand smoke policies were in place, and just went around and started stopping in at each of these buildings and finding out. And for the most part, the office buildings are all smoke-free. We stopped not just at office buildings, which would house hundreds of workers, but we also stopped in at little mom-and-pop shops.

And altogether, we visited 231 business locations, and we centered City Hall as the pinpoint and went out three or floor blocks in each direction. We also contacted several members of Philadelphia's Chamber of Commerce to learn about their smoking policies.

What we found was rather surprising

when we started putting the data together, and I'll include this list with my testimony. But, you know, if you go to a hair salon, there is no smoking there, so if you work in that business, you can breathe smoke-free air. If you work in a school or in an accounting office or if you work in a law firm, the air is clean there. If you work in a bank or for an insurance firm, or even in a dry cleaner, if you sell hats or eye glasses, greeting cards, wigs, computers, books, bikes, men's suit, women's dresses, or lingerie, you will not be forced to breathe an air full of carcinogens.

In fact, when I visited these places of business, they looked at me like I was kind of crazy, like why would we even have cigarette smoke in here? it would ruin our clothing. You know, people would have to go outside.

Even if you sell cigarettes, chances are, you won't have to breathe the smoke emitted from them. When I went to Wawa, the clerks told me that they have a have a very strict no-smoking policy and that several of their customers that come in to buy all the cheap cigarettes on sale

complain and say, Hey, you'll sell cigarettes to us but you won't let us smoke in here? But much to the credit of Wawa executives, they have a policy that protects the health of their workers.

And the City of Philadelphia has declared all buildings to be smoke-free. And without mentioning any names here, where enforced, City workers are all protected from breathing secondhand smoke.

However, there were 55 workplaces that allowed smoking, and 47 of these were related in some way to the hotel, bar, or restaurant industry. For waiters and waitresses, restaurants are workplaces. For waiters and waitresses, restaurants are workplaces. Employers in most businesses have taken some steps to protect employees from secondhand smoke, but waiters and waitresses and the other people who are affiliated in that business are typically the last group of workers to be protected.

The Health Promotion Council has worked with restaurants over the past two years to encourage them to go smoke-free. The owner of Bob's Diner in Roxborough stands out, because he

was a nonsmoker and was working six days a week, from 6 in the morning till 8 o'clock at night, constantly exposed to secondhand smoke. And when he went to his doctor, the doctor said that his heart rate and his lung capacity was that of a chain smoker, and that if he didn't stop smoking, that he would become very, very sick and die an early death, as his father did. And Bob said that he didn't smoke at all and that all of these effects were as a result of secondhand smoke.

So he took the very bold step of turning his diner into a smoke-free restaurant. And he did it for his own health because he said it doesn't matter how much money I make if I'm not here to enjoy it. And his restaurant, by the way, is doing very well. And I think he took that step because he really saw his own health on the line.

And what we've learned, just even in this recent interview of going around to restaurants, I've talked to restaurant owners and employees, and they're afraid. The reason that they haven't gone smoke-free, for the most part, is because they're afraid that they're going to lose business. And they have said to me, "Why

don't you just pass a law like they did in California or in Massachusetts? because I want to go smoke-fee, I hate cigarettes. You know, people sit there and they smoke cigarette after cigarette and they take up tables and they leave their ashes all over, and I have to breathe it in and I smell like cigarettes and I know it's bad for me."

One young hostess, I asked her, Are you a smoke-free restaurant? And she gave me a look, rolled her eyes and said, "No, but I make them sit way in the corner." So, I mean, some restaurant find a way around the law, but I think they're really looking for our help in promoting a healthy work environment for themselves and for their family.

I just want to include that from the Journal of the Medical Association, they reported that heavily exposed restaurant workers breathe the equivalent of actively smoking one and a half to two packs of cigarettes a day, and that in California, a waitress is considered the most hazardous occupation for women in the state. Compared to other female workers, waitresses are almost four times as likely to die from lung

cancer and two and a half times as likely to die from heart disease. And in Massachusetts, the Department of Health, in November 1995, reported that waiters and waitresses in Massachusetts have a 50 percent greater risk of lung cancer compared to other occupations.

One hotel in this city that doesn't allow smoking in the lobby, but if you want to smoke, you can just go over to the corridor there and smoke, has a sign proclaiming that "our employees are our greatest asset." Well, I think our citizens and our workers here in the City are our greatest asset and that it's important for us to protect their right to breathe clean air while they earn a livelihood.

Thank you.

COUNCILWOMAN TASCO: Thank you.

Miss Millenbach, would you please try to summarize your testimony since it contains a lot of information that's already been presented. It would be very helpful.

MS. MILLENBACH: Of course. I've already looked through it to see what is repetitive. And I'll skip the entire first page.

COUNCILWOMAN TASCO: Thank you.

MS. MILLENBACH: In fact, except for the introduction. My name is Rachael Millenbach, and I am the Director of the Health Promotion Council of Southeastern Pennsylvania's Tobacco Control and Prevention Program. And as Mary said, we're also known as TEACH, which as Darlene Messina alluded to, we do a lot of and have done a lot of prevention education work with youth over the years. And certainly as funding comes our way, we will be delighted to join in with the City and doing that with the School District.

COUNCILWOMAN TASCO: What about the funding that the City gets? You talked about $100,000 in the fines that the City receives from enforcing the tobacco code. Have you applied for any of that money from the City?

MS. TRACY: Yes. Actually, we are now subcontracted by the Department of Health to help enforce the law, and we train youth and we go out and respond to the calls that come into the hotline and run and sign our compliance check. So that money is used to help fund the ongoing compliance of the laws that were passed here.

COUNCILWOMAN TASCO: Okay, thank you.

MS. MILLENBACH: I want to address a little bit the health effect of secondhand smoke in terms of the worksite and policies that are taking place in other cities.

Nationally, there's a growing tend to eliminate smoking in the workplace. In 1986, when the Surgeon General's report came out, 2 percent of all worksites had a smoking policy. In a 1992-1993 national survey, 81.6 percent of workers reported that their workplace had a formal smoking policy, and 46 percent were smoke-free.

In addition, the shift that's been going on is a change in attitude among Americans. An increasing number of Americans are in favor of policies that protect us from secondhand smoke in the workplace. In the 1993 report from the Centers for Disease Control, the majority of employers, including smokers, support smoke-free workplace policies. In that survey, only 5 percent opposed the idea of restricting smoking in the workplace.

I'd like to mention something that's not in my testimony. When other staff members and

myself have gone out to hundreds of schools in the five-county area to educate youth about smoking, one thing we make sure that we say in every presentation to the kids is that smokers are not bad people. Sometimes, you know, there tends to be a schism and an us-and-them mentality, and that's not what this is about. And a lot of times, people kind of try to push it to that issue, to try to create controversy. I myself am a former smoker. Smokers are people who are addicted to nicotine -- nothing more nothing less -- and I think we need to remember that.

In 1994, speaking of children, the Pro Children Act went into effect as part of Goals 2000 Educate America Act. It required that smoking not be permitted in any indoor facility that services children and receives federal funding. Five years later -- this was a little revolutionary then -- we now expect that children should be able to go to school and that nobody should be smoking there, and we still have smoking in school bathrooms and things like that, a lot of problems to address, but we kind of accept as a premise that this makes sense.

COUNCILWOMAN TASCO: Who's smoking in the bathrooms?

MS. MILLENBACH: Excuse me?

COUNCILWOMAN TASCO: Who's smoking in the bathrooms?

MS. MILLENBACH: Well, sometimes we have students smoking in the bathrooms in schools. That's a problem that needs to be addressed. Sometimes we even have faculty members smoking in faculty restrooms.

COUNCILWOMAN TASCO: And that's banned.

MS. MILLENBACH: What?

COUNCILWOMAN TASCO: It's banned?

MS. MILLENBACH: Exactly. At this point, we accept that we have the right to fly on domestic flights and not have to breathe smoke. As Mary pointed out, if you work in the service industry, you're more likely to have to breathe environmental tobacco smoke.

I've so often heard the comment, "Well, if it really bothers you, get another job." We all know it's not that simple. If it were that simple, there would be a lot of problems in life that we would just get rid of.

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Let me skip some stuff here. I've had a personal experience with this matter. When you have people working in businesses where people smoke -- and I think this survey that Mary and our student-interns did was around Center City, it was within four blocks of City Hall. I suspect that if we went out and did this same survey in neighborhoods that we would find a different story: we would find a lot more businesses allowing smoking going on there.

Some people may not care; the smoke may not bother them, whatever, they don't care. Other people may care but feel like they can't say anything about it for a variety of reasons. Some may be like my sister, who had to go out on short-term disability with bronchitis because of the smoke in her office. This happened after a long, drawn-out and, obviously, unsuccessful battle to get her employer take her pleas seriously.

After returning to work, she was again exposed to smoke and had a terrible cough that lasted for another two months. Because she fears retaliation, I can't tell you her name, where she

lives or who she worked for. She does, by the way, work for a very large accounting firm and very white-collar professionally and, at the time, in a very professionally-oriented office building. So we shouldn't assume that everybody's protected.

Not a lot of people have sisters who direct tobacco-control programs who are in this situation and can call up periodically over a 12-month period and say, "Help, what do I do? I need you to help me figure this out." None of my suggestions really helped solve the problem. It all came down to whether or not the city that she lives in had an active smoke-free legislation at the worksite or not.

This story has a happy ending. She now works in a smoke-free environment only because the company that she works for had to move, and they ended up moving into a smoke-free building.

The right to breathe safe and clean air should not depend on luck. Some states have laws restricting smoking, many provide few protections for the general public. Three states -- California, Maryland, and Washington -- eliminate

smoking in the workplace, with the restrictions in Maryland and Washington restricted to office worksites. Three states -- again California, Utah, and Vermont -- eliminated smoking in restaurants.

Fortunately, the situation is much better at the local level. According to the Americans for Nonsmokers Rights Foundation, as of October 1998, there were over 820 local ordinances in the U.S. that restricted smoking to a meaningful degree. Of these, 623 restrict smoking in private workplaces and 738 restrict smoking in restaurants. Another 556 ban smoking in all enclosed public places, except for those specifically exempt in the ordinance.

In New York City, the Smoke-Free Air Act, which virtually prohibits smoking in all public places, went into effect in 1995. Years later, they realized that their law wasn't strong enough, and now they are in the process of seeking even stronger measures to protect the health and safety of New Yorkers.

In 1998, the Boston Health Commission enacted legislation that required restaurants to

be smoke-free. To quote the Boston regulations, "After having reviewed the record of testimony and public commentary, the Boston Public Health Commission arrives at the following findings for the express purpose to: 1. Protect the public health and welfare citizens by restricting smoking in restaurants; 2. To protect smoke-free air for nonsmokers; and 3. To recognize the need to breathe smoke-free air; shall have priority over the desire to smoke in an enclosed public space."

I have included information from Boston, not because we're here to discuss restaurants, per se, but because I find the third clause particularly compelling. "The need to breathe smoke-free shall have priority over the desire to smoke in an enclosed public space."

This simple statement addresses one of the tobacco's tactics when they frame the issue as an attack on the individual smokers' rights to manage their own personal habits. When lobbying against smoke-free ordinances around the country, the opposition uses language that creates an us-and-them mentality.

In reality, we are a group of

individuals, some of us smokers and some of us nonsmokers who share space in the fourth largest city in the United States. To protect all of us from a major public health hazard is the obvious direction to take.

Now, one might ask, why is the tobacco industry and their allies so invested in destroying smoke-free efforts? According to a confidential report prepared for the Tobacco Institute by the Roper Organization in 1978, the growing nonsmokers' rights movement is the most dangerous development to the viability of the tobacco industry that has yet occurred. It's fun to think about how much as occurred since 1998. Because smoke-free worksite policies have a strong positive correlation with individual attempts to quit smoking, there is a strong incentive for the tobacco industry to squash all local, state and national efforts to protect the health of our nation.

As part of my work as coordinator of the Philadelphia Smoke-Free Dining Campaign, I've had the opportunity to speak with many restaurant owners who allow smoking in their restaurants. As

Mary mentioned, by far, the common response is fear that they will lose business if they eliminate smoke from their establishment.

This is very understandable, especially given the fact that for years, the tobacco industry has circulated economic impact studies showing that clean indoor air legislation in restaurants and bars is harmful to sales. To the contrary, many studies have shown regulations result in equal or greater restaurant sales revenue.

Intuitively, this makes sense, given that approximately one-quarter of the U.S. Adult population smokes and three-quarters do not. Additionally, people who smoke also need to eat and do not necessarily oppose smoke-free environments for their dining. In fact, some smokers are grateful that they cannot smoke at work since it supports them in their efforts to reduce or quit smoking.

I'm not going to read all of this since I think people are getting anxious about time.

COUNCILWOMAN TASCO: But your testimony will be a part of the public record.

MS. MILLENBACH: Exactly. What I've done is, I've listed data from a lot of places from around the country that have done studies on worksite smoking. And there's, you know, as all the physicians stated in terms of the clinical and medical evidence, the evidence was really overwhelming.

This is not about facts, this is about money and politics and other issues like that, that we won't get into.

We have been given an opportunity today. An impressive and distinguished group of health-care and public-health officials have condensed volumes of overwhelming data into a few short areas. There's a wealth of information that clearly indicates the link between environmental tobacco smoke, illness, and death.

After absorbing all of the information presented here today, we must consider the next step. If members of City Council and Mayor Street are truly committed to the public health and the economic health of our city, we must take decisive action smoking. Smoking is the number-one cause of preventable death in the United States, and

death from exposure to ETS is the third leading cause.

When the time comes, please don't be fooled by the tobacco industry and their front groups. Setting restrictions like those in place all over the country will not harm the local business community, it will not destroy our rights as individuals. It put us in line with the growing number of other U.S. cities, it will protect all Philadelphians, smokers and nonsmokers alike, from the harmful effects of breathing a Group A carcinogen. In any other situation, we would not allow arsenic, butane, and carbon monoxide into the air we breathe at work. We don't ask for a few scoops of napthalene, otherwise known as "moth balls," with our breakfast cereal. And we certainly don't dab on a little formaldehyde before going out on the town.

Thank you.

COUNCILWOMAN TASCO: Thank you very much for your testimony. I appreciate it very much.

We'll now have representatives from the License Beverage Association: Mr. Joe Mallamaci,

Tom Salmons, and Prince Gilliard (ph.).

MR. MALLAMACI: Members of the Committee, please allow me to extend my gratitude for the opportunity to address the committee on this important economic issue.

COUNCILWOMAN TASCO: Please identify yourself for the record.

MR. MALLAMACI: My name is Joe Mallamaci, and I'm the President of the Philadelphia Licensed Beverage Association. I am also a tavern- and restaurant-owner.

COUNCILWOMAN TASCO: Excuse me, please. Spell your name for the stenographer.

MR. MALLAMACI: M-A-L-L-A-M-A-C-I.

Without your objection, I would like to request that I be allowed to submit a revised and extended version of my testimony for the record.

On behalf of our membership, I testify before you today in opposition to a proposed smoking ban in bars and restaurants in the City. The real issue for my membership is not smoking, but the economics and the freedom of choice.

If the City Council of Philadelphia were to institute a smoking ban, Council, it would

be proposing a terrible burden. Those who would be most impacted by such ban economically are not large chain restaurants, which tend to be insensitive corporate giants, but rather, the numerous small mom-and-pop business owners, which dominate every section of this great city. If such an ordinance were to pass, there's a large group of restaurants that would not be able to survive.

Let's learn from the example of other municipalities who have attempted to institute smoking bans. I won't take up your time reading all of the following comments of the economic impact on smoking bans throughout the country, but as you can see in the testimony passed out to you, the adverse effect it has on our industry.

An employee states in Anaheim, California, "I do not smoke. However, I tended bar for several years and have already seen the dramatic decrease in business since the ban went into effect." If businesses are forced to close, expect unemployment benefits and welfare rates to rise. My advice to you is, if you can't stand the smoke, stay out of the bar.

In Fort Wayne, Indiana, a City Council survey of restaurants found that earnings at all but one of the 24 restaurants surveyed were down 5 percent to 24 percent. One manager, Martin Doves, said that since the ordinance passed, he's been losing $4,000 a week. Many customers are flocking to food-serving bars where smoking is permitted.

As quoted in the nation's Restaurant News, in August of '99, the report found that alcohol sales had fallen by about 14 percent, and restaurant sales had recorded a 5 percent drop since the ban was implemented. Meanwhile, employees' tips had declined 15 percent, wages and salaries paid out to employees were down about 6 percent, and 142 people had lost their jobs.

In addition, if Council were to choose to ignore the economic impact of such an ordinance and institute a prohibition on smoking in bars and restaurants in this city, we would see a large percentage of our business merely crossing the line into Delaware, Camden, Montgomery, or Bucks County.

Now I would like to address the

controversy on secondhand smoke. The bottom line is that there is no scientific basis to make the claim that secondhand smoke causes lung disease. According to a recent Congressional services report on secondhand smoke, an individual stands a higher risk of getting killed on the national beltway than by secondhand smoke.

There are some who argue that the U.S. Environmental Protection Agency concluded in 1993 that it causes lung cancer. What they won't tell you is that in 1998, U.S. District Judge William Osteen issued a summary judgment in challenge to the EPA's report entitled "Respiratory Health Effects of Passive Smoking, Lung Cancer and Other Disorders."

It may be politically correct to attack secondhand smoke, but it is not scientifically correct or legally correct. The EPA abused its power in an effort to force state and local government to pass smoking bans, when the scientific basis for those bans simply did not exist.

The court's ruling highlighted numerous errors in its scientific process as well as the

procedural failings. The EPA's conduct of the ETS risk assessment frustrated the clear Congressional policy underlying the Radon Research Act. EPA's actions underscore the urgent need for honest, open public-policy debates about public smoking, the need for reasonable solutions to accommodate the preferences of smokers and nonsmokers, and the need for greater oversight to ensure that governmental agencies don't abuse their authority of power.

I thank you for this opportunity to present our views. And at this time, I would like to turn it over to our Chairman of the Board, Tom Salmons.

COUNCILWOMAN TASCO: Thank you very much.

Mr. Salmons, would you please identify yourself for the record.

MR. SALMONS: My name is Tom Salmons, S-A-L-M-O-N-S.

COUNCILWOMAN TASCO: Thank you.

MR. SALMONS: Thank you, Council.

As a bar owner, I'm assuming that this is just the beginning of a ban on smoking in bars

and restaurants. In front of you, there's a copy of Atmosphere Plus, which is a way and the equipment to clean our air in our establishments. We just want the opportunity to do that, not a ban. Maybe we could put a sign on the front door, "Smoking Tables Not Available," or so on for the small places. Most of the bars and restaurant nowadays do have smoking areas available where the air is clean.

COUNCILWOMAN TASCO: You mean nonsmoking?

MR. SALMONS: Nonsmoking, excuse me.

It would hurt our business I'm in my tavern 7 days a week, and 9 out 10 of my customers smoke. I personally don't smoke. I have smoke-eaters, ventilation, exhaust systems that keep air pretty clean, 'cause I'm in there all the time too.

What we're looking for is just some compromise here, to give us a choice of whether -- you know, if it's banned completely, that's going to hurt our business. I don't want my customers standing outside my place, number one. I'm in a residential area. If you have like ten or fifteen

people out there smoking, it might be a little later at night, making noise, then my neighbors are going to be upset at me. That's pretty much the reasons behind my small tavern and where I'm at.

In your packet, there's also a copy of a study -- it's on Page 9, next to the last page -- from Oak Ridge Laboratories, that suggested secondhand smoke exposure is lower than first noted. Philadelphia is one of the places studied in there.

And that's all I have to say and I thank you for your time.

COUNCILWOMAN TASCO: Thank you very much.

Mr. Gilliard, would you identify yourself.

MR. GILLIARD: My name is Prince Gilliard. I'm President of the Philadelphia Licensed Tavern and Merchants Association. And I want to thank the City Council for giving us this opportunity to express our concern about this proposed bill.

Personally, I don't smoke, but I

believe in freedom of choice. I've been in this business for over 35 years and I've seen the steady decline in our industry. And I would certainly like to see more study on the smoke-eaters and see what effect they might have in reducing the smoke in our locations. And if this bill was to pass, it would certainly be a devastating effect on the industry.

So, Madam Chairman, I'd just like to see more study on the bill. I concur wholeheartedly with my colleagues here that there's been so many legislations in our industry that it has made a decline in our industry. At one time, we had over 600 licensees; now it's down to a little over 300. And it's a steady decline.

So I'm concerned about if this bill were to pass, the customers would just move to Camden, Montgomery County, Bucks County. It would also be a terrible drain on our city for the tax that we'd be collecting, because the business would certainly decline. So with the 10 percent tax we've learned to live with, our customers we have now say it's in place and they're agreeable to pay that tax. But what would happen if this

particular bill should pass? It would be a drastic drain on our city because we'd be losing income from our business.

So I would certainly hope that City Council would give this serious consideration and look more at the smoker-eaters and see what effect that might be in eliminating the smoke in our establishments.

Thank you for allowing us to make this presentation.

COUNCILWOMAN TASCO: Thank you very much.

We're not at the bill point yet. This resolution today is just to have discussion on the impact of environmental tobacco smoke, and to -- it's an information-gathering process. There is no bill before Council to control or eliminate smoking at this time. This is just an information-gathering hearing on this resolution.

And certainly, if anything of the nature should come forth, you know, you will be notified. But we appreciate your coming forth to testify as always to support your industry.

MR. GILLIARD: Thank you.

COUNCILMAN NUTTER: I have a couple questions.

COUNCILWOMAN TASCO: Councilman Nutter -- oh, I'm sorry, then Councilman Rizzo.

COUNCILMAN RIZZO: Thank you, thank you Madam Chair. No problem at all.

If a year ago I heard -- I'm very confused on exactly the position of how I want to express myself. I would totally agree with you if something didn't occur a year ago that your customers would leave and go to New Jersey or go to the suburbs or wherever. I would have totally agreed with you.

But I have experienced something in my neighborhood. You all know the name "McNally's." It's a neighborhood bar, it serves a little bit of food. And a year ago, it went smokeless.

Can you help to explain to me how that bar -- and according to the owner -- has increased in its patronage rather than decreased? How could that be?

MR. GILLIARD: Let me just address that, Councilman. One location I'm sure you're very familiar with it -- the Pub, in Camden. The

Pub went smoke-free. Their location lost so much business, they had to reverse that, and now they allow the people to come in and smoke in the Pub.

COUNCILMAN RIZZO: Well, let's talk about McNally's in northwest Philadelphia, a neighborhood establishment that's been there for, I think, a hundred years that does -- serves a great sandwich, not a real elaborate menu. You walk in there on any given day, it's jammed to the door.

And when we heard in the neighborhood that it went -- and I don't smoke -- that it went smokeless, we said, Well, this is great, now we'll be able to get a seat anytime we want. And now, it's almost impossible to get in the front door.

And I thought -- and unless I experienced that personally -- maybe it's just because it's one place. You know, and I just can't -- I don't have a rationale to explain how that happened.

MR. SALMONS: I would think that just because it is one place. If all the other taverns and restaurants in the City were to be smoke-free, then that would divide it all up.

MR. MALLAMACI: And I think what will work for one may not work for everyone.

COUNCILMAN RIZZO: Well, in trying to be fair here, I think what Ann told me -- and you know the place seats about 45, 50 people at the max -- a lot of customers, since it is one of the few that don't smoke, go there specifically because it's a smoke-free environment. But what she did tell me was that all of her patrons that did smoke when she adopted the policy, never once has she had a person be rude. Occasionally, some of them will light up that's not familiar with the establishment, and the bartender will just politely tell them it's smoke-free, and they'll just quickly run out the door and come right back after they smoked their cigarette.

But I just wanted to -- maybe you could help me 'cause I've been struggling with that since it went smoke-free there.

MR. SALMONS: Right. I think it's just because there's one, it's of the only. And that was my other point -- I don't want my customers all out in front of my place. I have residential all around me, and I like to keep it quiet.

MR. MALLAMACI: For those that are more family-oriented, it may work for them, but for some of us that are more youth-oriented, that might be a sports bar, it may not work for. What works for one person may not work for another.

COUNCILMAN RIZZO: Thank you. Appreciate that.

Thank you, Madam Chair.

COUNCILWOMAN TASCO: Councilman Nutter.

COUNCILMAN NUTTER: Thank you, Madam Chair.

Good afternoon, Mr. Mallamaci, Mr. Salmons, and my good friend Prince Gilliard. A couple questions on the testimony and the presentation.

Mr. Mallamaci, I was struck by a couple portions of your testimony, but one of the pieces kind of concludes that it was not scientifically correct to try to attack secondhand smoke. Your primary background is in the food and beverage industry?

MR. MALLAMACI: Yes.

COUNCILMAN NUTTER: Okay. And you've been in the industry for a long time?

MR. MALLAMACI: Pardon me?

COUNCILMAN NUTTER: Have you been in the industry for a long time?

MR. MALLAMACI: Yes, I have.

COUNCILMAN NUTTER: Okay. Do you have a doctor?

MR. MALLAMACI: No, I don't.

COUNCILMAN NUTTER: I'm sorry?

MR. MALLAMACI: Do I have a doctorate?

COUNCILMAN NUTTER: No, a doctor. I mean, do you see your doctor from time to time?

MR. MALLAMACI: Oh, yes, I do. Yes, I, do.

COUNCILMAN NUTTER: Okay. That's because you might be ill or you trust the doctor's judgment.

MR. MALLAMACI: To get a checkup occasionally, yes.

COUNCILMAN NUTTER: Okay. So you trust the doctor's judgment?

MR. MALLAMACI: Yes.

COUNCILMAN NUTTER: Okay. I don't know what you were testifying from, but your testimony seemed to be in direct contradiction to Dr.

Simmons, Dr. Greenspan, Dr. Willis, Dr. Leone, Dr. Piatt, and Dr. Emmett.

Now, is there something that you know about smoking or secondhand smoke that is different or more knowledgeable than those trained professionals?

MR. MALLAMACI: No. I was just quoting from the literature that I had received from the Oak Ridge report.

COUNCILMAN NUTTER: I'm sorry?

MR. MALLAMACI: I was just quoting from the information I had received from the Oak Ridge National Laboratory.

COUNCILMAN NUTTER: And who are they? Who's the Oak Ridge National Laboratory?

MR. MALLAMACI: Yes.

COUNCILMAN NUTTER: Who are they?

MR. MALLAMACI: They are the, um --

COUNCILMAN NUTTER: Is that in the materials here?

MR. SALMONS: Yes.

MR. MALLAMACI: Yes, the last page.

COUNCILMAN NUTTER: What page?

MR. MALLAMACI: The last page.

MR. SALMONS: It's next to the last.

COUNCILMAN NUTTER: I'm sorry, it's after Page 8, okay.

MR. SALMONS: It has "Oak Ridge" right at the top.

COUNCILMAN NUTTER: And who owns the Oak Ridge National Laboratory; do you know?

MR. MALLAMACI: I really don't know.

COUNCILMAN NUTTER: Okay, but you think that their study is better than anything concluded either by the United States Environmental Protection Agency or eight local doctors here who are specialists, if not preeminent, in their field?

MR. MALLAMACI: I believe, um. . .

This research was done, if I'm not mistaken, to the last page, was funded by the Center for the Indoor Air Research facility, managed by the Lockheed-Martin Energy Research Corporation.

COUNCILMAN NUTTER: Okay. And do you know who funded that study?

MR. MALLAMACI: No, I don't, sir.

COUNCILMAN NUTTER: Okay. Do you know

if they're associated in any way with a company by the name of Options?

MR. MALLAMACI: Of who?

COUNCILMAN NUTTER: Options? Have you ever heard of Options?

MR. MALLAMACI: No, I haven't.

COUNCILMAN NUTTER: Options is a company affiliated with Phillip Morris. They do a lot of research in this particular area. So, I mean, you might understand where their perspective might be on something like this.

Okay, I just wanted to understand what the basis of your knowledge in the area was as compared to the eight doctors who had testified and the United States Environmental Protection Agency.

Mr. Salmons, on the presentation materials, which are excellent, this Atmosphere Plus, now, why is it that you recommend that you should have these? What is this, a device, or is this a type of ventilation?

MR. SALMONS: It's all types of ventilations.

COUNCILMAN NUTTER: Okay. And why

would you put one of these in your place?

MR. SALMONS: If the smoke is bothering people, it would eliminate the smoke from the establishment.

COUNCILMAN NUTTER: Well, I thought Mr. Mallamaci said that there's no evidence to indicate that smoke bothers people or is dangerous to their health.

MR. SALMONS: It's just giving us an option, that's all.

COUNCILMAN NUTTER: Well, why would you need it if it wasn't dangerous to someone's health?

MR. SALMONS: 'Cause people are complaining about it.

COUNCILMAN NUTTER: Why are people complaining about it?

MR. SALMONS: From the testimony I heard, it's mostly about children. And most of our establishment is --

COUNCILMAN NUTTER: Well, I thought there was a fair amount of testimony about adults as well.

MR. SALMONS: Right. And my father

died of cancer and he didn't smoke.

COUNCILMAN NUTTER: I understand and I'm sorry about that.

MR. SALMONS: I never could figure out the connection.

COUNCILMAN NUTTER: The connection, yeah.

I think Councilman Rizzo had asked one of the doctors about how some people never smoke and they get diseased and some people smoke all their lives and nothing seems to happen to them. Some may be environmental, some may be hereditary some is, you know, I guess, kind of the luck of the draw.

But I was intrigued that there would be a device to remove something from the air at the same time that people are saying that there's no problem with the air, or it's not an irritant or it doesn't bother people, or has no ill health effects. Then I don't understand why you would need to remove it. I mean, if it's good for you, why would you want to take it away?

MR. SALMONS: Well, I understand that, but anybody that smoke, if it goes in your eyes,

it burns, and some people are allergic to it.

COUNCILMAN NUTTER: So it's bad.

MR. SALMONS: Yeah. I don't smoke, but if I can clean the air up so people have choice, then. . .

COUNCILMAN NUTTER: Well, let me ask this question, just about the nature of the business -- not so much the business, your membership.

MR. SALMONS: Yes.

COUNCILMAN NUTTER: And it's kind of primarily bars and taverns.

MR. SALMONS: Mostly small taverns.

COUNCILMAN NUTTER: Okay. Is there any technical difference between a bar and a tavern? Is a tavern a kind of a larger bar or maybe has a more extensive menu or something like that?

MR. SALMONS: Food-wise.

COUNCILMAN NUTTER: What's -- for your membership, I mean, you won't know this about me, but Mr. Gilliard does. I have previous experience in the bar and restaurant business and industry some many years ago, in a previous life, before I got here. I mean, is there an average size bar in

this city or of your membership?

MR. MALLAMACI: I think they vary.

COUNCILMAN NUTTER: Well, I know they vary but, I mean, within some ranges, is it 20 seats at a bar or 30 seats at the bar?

MR. SALMONS: We have places like Finnegan's Wake that has three floors. Compared to my place, I hold like 40 people. And there's a difference.

COUNCILMAN NUTTER: And I know by way of the LCD regulations that if you have Sunday sales, you have to have, what is it, 30 chairs?

MR. SALMONS: 30 chairs and tables.

COUNCILMAN NUTTER: 30 chairs and tables to go with it.

MR. SALMONS: Right.

COUNCILMAN NUTTER: Well, let me ask this question. In terms of -- and certainly don't share any proprietary information, and the Department of Revenue is not here, I can assure you of that.

On average, what would you say the split was between your liquor sales and your food sales? And, again, acknowledging, I know, if you

have a Sunday sales permit, you are supposed to sell a certain minimum primarily. I mean, you're primarily in the liquor business?

MR. SALMONS: Personally mine is like 60/40 -- 60 bar, 40 food.

COUNCILMAN NUTTER: Okay. Mr. Gilliard, do you have any perspective on this?.

MR. GILLIARD: Yes. That ratio with mine would be about 70/30, maybe 30 percent food and 70 percent liquor.

And let me just say this. Our concern is also for the small operator in this business. And when I say "small," it's one with the location, one level. Say, for example, if it came to a point where there was a bill that should pass, I have two levels in my location. So I could take one level and make it for the nonsmokers. But most of our members, I'd say 85 to 90 percent, don't have that luxury. And it's our concern for those --

COUNCILMAN NUTTER: When say "members," you're not talking about members of your establishment but of the Philadelphia Tavern organization, right.

MR. GILLIARD: Members in the City of Philadelphia. They don't have that luxury of having the two levels, and it would certainly be a drastic impact on their business to make their entire level nonsmoking.

COUNCILMAN NUTTER: Mm-hmm, okay. But between the two organizations, you do think that -- I mean, somewhere in the 60, 70 percent for what your business is as compared to, for instance, a downtown restaurant.

MR. GILLIARD: Yes.

COUNCILMAN NUTTER: You serve food to a lot of those people who want snacks or something like that. I mean, they really kind of shouldn't couldn't drink on an empty stomach. That kind of thing.

MR. GILLIARD: Correct.

COUNCILMAN NUTTER: You're not really so much in the restaurant business, the food is not driving your business; the liquor is driving your business, and you serve food to go along with it.

MR. GILLIARD: Yes, right.

COUNCILMAN NUTTER: You serve food to

go with it; is that fairly accurate?

MR. GILLIARD: Yes, yes.

MR. SALMONS: Yes.

COUNCILMAN NUTTER: Okay, I appreciate that. I will certainly read through all of these materials.

As the Chair said, this is on information-gathering hearing. I appreciate your testimony. You're trying to, you know, I mean, anticipate the prospect of the future. For the moment, we are just gathering information, but your testimony has been very helpful in terms of shaping some of the discussion and dialogue that's taken place today.

And because you have been so decent about it, I will not, Mr. Mallamaci, get into an extensive debate with you about EPA and 900 studies and who's got the best numbers and all that kind of stuff, because you've been very nice, and it's also kind of late in the day.

Thank you.

MR. SALMONS: Thank you.

MR. MALLAMACI: Thank you.

COUNCILWOMAN TASCO: Is there anyone

else here to testify on this resolution? Dr. Kessler?

(Dr. Kessler comes forward.)

COUNCILWOMAN TASCO: Good afternoon.

DR. KESSLER: Good afternoon.

COUNCILWOMAN TASCO: We have been here quite some time and heard a lot of statistics and information. If you could summarize.

DR. KESSLER: My name is Howard Kessler. For the record, I'm a physician licensed to practice medicine in the Commonwealth of Pennsylvania. At the present time, I'm Chairman of the Department of Radiology at Graduate Hospital. But I come to you today on behalf of the American Cancer Society. I am the President of the American Cancer Society for the Southeastern Pennsylvania Region, which represents of four counties surrounding Philadelphia as well as Philadelphia County.

In my career prior to that, I was the Director of Imaging at Fox Chase Cancer Center for the past 14 years. And in that capacity, I have been intimately involved with the observation, the detection, and the diagnosis and treatment of

cancer.

And I recognize that the hour is late, and I always keep my remarks to just a few minutes, and I'll let the prepared statement serve for the record, but I would like to put a couple things on the table for distinguished members of Council and those who are here both for as well as against this resolution.

We all know that cancer has been linked to smoking since the Surgeon General's comments from 1964. According to the 1985 report of the Surgeon General on the health consequences of smoking, cancer and chronic lung disease in the workplace, the Surgeon General concluded that the combination of smoking with exposure to hazardous substances at the workplace presents a serious health risk.

We have known for 21 years, since the Surgeon General's report of 1979, that smoking and health and cigarette-smoking in the workplace can do the following four things: transform existing chemicals into more harmful ones; increase exposure to existing toxic chemicals; add to the biological effects of certain chemicals; and

interact synergistically or in combination with existing chemicals.

I think the evidence is incontrovertible that smoking, both primary smoking as well as passive or secondhand smoke, has been linked to lung cancer. And I would like to site for the record three peer review studies that have documented this.

This information serves as a matter of public record by the Surgeon General and the National Academy of Sciences, and they have examined and have concluded that involuntary study in the exposure to other people's smoke increases the risk of developing lunch cancer. This occurs at the workplace and at home. And articles published by the Department of Health and Human Services, through the National Institutes of Health, in 1993, clearly documented as much as a 20 percent increase in the risk of lung cancer for those individuals who live with or work with those who smoke.

Nonsmokers married to heavy smokers in excess of 40 cigarettes a day are found to have two times the risk of cancer compared to those who

are married to nonsmokers. And nonsmokers married to current smokers have a 20 percent higher risk of coronary artery disease.

And these are from documented peer-review articles published in the literature. So I think it goes without saying that secondhand smoke is harmful.

And as you've heard in prior testimony, the Environmental Protection Agency has identified an estimate of 3,000 cases per year of nonsmokers who have been afflicted with lung cancer. And I will tell anecdotally from my experience as a radiologist who has watched and has seen the progression of this disease in individuals, it takes a terrible toll on the individual, on the family, on society.

And I think it's incumbent upon us to recognize that although we have made great strides in encouraging smoking cessation in public places, we need to go further, we need to ensure that the workplace, for reasons related to lung cancer, for reasons related the estimated 50,000 related deaths that are unrelated to lung cancer that occur from secondhand smoke, and for the next

generation of our citizens, that we provide them with an environment, both in school at work and at home, where they have the opportunity to breathe clear air.

And, finally, I'd just like to close by offering you one statement, which I think may surprise you. It's estimated that only 15 percent of the smoke from a cigarette is inhaled by the smoker; the other 85 percent goes directly into the air and is referred to as "secondhand smoke." Secondhand smoke is a combination of mainstream smoke, which is inhaled and exhaled by the smoker. And this, when combined with sidestream smoke, which comes from the cigarette between puffs, contains far more tar, nicotine, carbon monoxide, and other chemicals that cause cancer than the smoke inhaled by the cigarette itself.

So in closing, I'd like to thank you for the opportunity to present my view in front of you, both as a physician, as a volunteer for the American Cancer Society, and as individual who would like to see his children and your children grow up in as close to a smoke-free environment as they can.

Thank you.

COUNCILWOMAN TASCO: Thank you very much for your testimony.

We have testimony from the Coalition for a Smoke-Free Valley, presented by Alice Dalla Palu, Executive Director, and that will be entered into the record as presented.

So we thank you for testifying we thank for testifying, we thank all of the people who participated today. And this committee hearing on Resolution No. 000172 is adjourned.

Thank you very much.

(Adjourned at 5:12 p.m.)

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C E R T I F I C A T E

I HEREBY CERTIFY that the foregoing proceedings of the Council of the City of Philadelphia of Tuesday, April 25, 2000, were reported fully and accurately by me, and that this is a correct transcript of same.

RE: COUNCIL COMMITTEE ON
PUBLIC HEALTH AND PUBLIC SAFETY
RESOLUTION NO. 000172

_____,
JOSEPHINE CARDILLO,
Registered Professional Reporter