NYPIRG

NEW YORK
PUBLIC INTEREST
RESEARCH GROUP

Testimony of Lauren Schuster
New York Public Interest Research Group
Before the Committee on Health and the Committee on Parks and Recreation
On Intro 0332-2010 to Prohibit Smoking in Public Parks, Beaches, and Pedestrian Plazas
October 14, 2010

Good afternoon and thank you for the opportunity to speak before you today. My name is Lauren Schuster; I'm a staff attorney with NYPIRG, the New York Public Interest Research Group. NYPIRG is New York State's largest and most effective social justice organization, with offices at twenty college campuses across the state. We work on a variety of issues, including environmental preservation and consumer protection, and have a long history of working to limit people's exposure to second-hand smoke and tobacco products.

NYPIRG commends Speaker Quinn, Councilmember Brewer, and Mayor Bloomberg for their continued commitment to making New York City safer and healthier by introducing legislation to prevent smoking in certain public spaces, typically frequented by families. Intro 0332-2010 would prohibit smoking in New York City's public parks, beaches and pedestrian plazas, and will go a long way to ensure that non-smokers can breathe easier and safely and cleanly enjoy the beauty of New York's public spaces.

According to the U.S Surgeon General, "there is no risk-free level of exposure to second-hand smoke. Breathing even a little secondhand smoke can be harmful to your health."[i] The United States Environmental Protection Agency has classified second-hand smoke as a "Group A" known carcinogen.[ii]

Studies have shown that outdoor levels of second-hand smoke can be as high as second-hand smoke levels indoors.[iii] Even with the ban on smoking in many indoor locations, the New York City Department of Health has found that nearly 60% of non-smoking New Yorkers show an elevated level of cotinine, a by-product of nicotine, in their blood.[iv] Elevated levels of cotinine demonstrate that despite the indoor smoking ban, our residents are still being exposed to dangerous levels of second-hand smoke outside.

9 MURRAY STREET, 3RD FLOOR • NEW YORK, NEW YORK 10007 • 212.349.6460 • FAX 212.349.1366
OFFICES IN: CAPITAL DISTRICT & HUDSON VALLEY, LONG ISLAND & NEW YORK CITY, WESTERN & CENTRAL NEW YORK

While outdoor smoking poses a clear health threat to all New Yorkers, it also poses a significant environmental threat. Cigarette butts, which can take many years to decompose, are the most common form of litter found in parks and beaches. Cigarette butts are not biodegradable, and can release toxic chemicals, such as nicotine, benzene, and cadmium, into the water where they are discarded. Cigarette butts also pose a risk to marine wildlife, which ingest the butts mistaking them for food. Recent experiments have shown that one butt has enough poisons to kill half the minnows in a liter of water in 96 hours.[v]

Finally, reducing the number of public spaces where smoking is permitted may help reduce the number of young people who view smoking as socially acceptable and ultimately, the number of young people who become smokers. According to a joint study by Blue Cross Blue Shield and the University of Minnesota, School of Public Health, there is an association between the frequency that youth observe smoking in various locations and the perception that smoking is socially acceptable. They concluded that, "policies that restrict smoking in various locations will reduce both visibility and perceived acceptability of smoking in those locations."[vi]

Intro. 0332-2010 will lead to cleaner and more beautiful public spaces, safer and healthier air for our residents, and may reduce the number of young people who begin smoking. All New Yorkers deserve the right to breathe clean air at our public parks, beaches, and pedestrian plazas. Passing Intro 0332-2010 would protect every single New Yorker's right to enjoy our public spaces without risking their health and well being. For these reasons, NYIRG respectfully urges the Council to pass Intro. 0332-2010. Thank you.

---

[i] Office of the Surgeon General, U.S. Dep't of Health & Human Services, *The Health Consequences of Involuntary Exposure to Tobacco Smoke: A Report of the Surgeon General*, Jan. 4, 2007, *at* http://www.surgeongeneral.gov/library/secondhandsmoke/factsheets/factsheet7.html.

[ii] *See, e.g.*, U.S. Environmental Protection Agency, *EPA Designates Passive Smoking a "Class A" or Known Human Carcinogen*, Jan. 7, 1993, *at* http://www.epa.gov/history/topics/smoke/01.htm.

[iii] *See, e.g.*, Klepeis et al, "Real-Time Measurement of Outdoor Tobacco Smoke Particles," Journal of the Air and Waste Management Association, 2007, 57:522-534, *avail. at* http://tobaccosmoke.exposurescience.org/real-time-measurement-of-outdoor-tobacco-smoke-particles; Hall et al., "Assessment of exposure to secondhand smoke at outdoor bars and family restaurants in Athens, Georgia, using salivary cotinine," *Journal of Occupational and Environmental Hygiene*, Nov. 2009, 6(11): 698-704.

[iv] Ellis et al., "Secondhand smoke exposure among nonsmokers nationally and in New York City," *Nicotine & Tobacco Research*, 2009, 11(4): 362-370, *at* http://ntr.oxfordjournals.org/content/early/2009/01/01/ntr.ntp021.full; *see also* N.Y.C. Dep't of Health and Mental Hygiene, "More Than 2.5 Million Non-Smoking New Yorkers Have Residue from Toxic Second-Hand Smoke in their Blood," April 8, 2009, *at* http://www.nyc.gov/html/doh/html/pr2009/pr011-09.shtml.

[v] *See* Leslie Kaufman, "Cigarette Butts: Tiny Trash That Piles Up," *New York Times*, May 28, 2009, A12, *avail. at* http://www.nytimes.com/2009/05/29/us/29cigarettes.html.

[vi] Alesci et al., "Smoking visibility, perceived acceptability, and frequency in various locations among youth and adults," *Preventive Medicine*, March 2003, 36(3): 272-281.

Written Testimony of
Theatre Communications Group
Submitted October 14, 2010 to
The New York City Council
Smoking Ban in NYC Parks and Public Spaces

Laurie Baskin
Director of Government & Education Programs
Theatre Communications Group
520 Eighth Avenue, 24th Floor
New York, NY 10018
(212) 609-5900 ext. 228, lbaskin@tcg.org

My thanks to the Members of the City Council for this opportunity to testify today. My name is Laurie Baskin. I am director of Government & Education Programs at Theatre Communications Group (TCG.) TCG is the national organization for the American theatre, and it exists to strengthen, nurture and promote the professional not-for-profit American theatre. Its programs serve nearly 500 member theatres, including 61 in New York City and more than 12,000 individuals nationwide. In all of its endeavors, TCG seeks to increase the organizational efficiency of its member theatres, cultivate and celebrate the artistic talent and achievements of the field and promote a larger public understanding of, and appreciation for, the theatre.

TCG appreciates the City's desire to improve the health of its citizens and wholeheartedly applauds all efforts toward that end. TCG is not encouraging people to smoke. At the same time, we would like to share with you the importance of theatrical smoking to our art form.

The tradition of employing theatrical smoking to express mood and tenor, to develop plot, and to typify a character's personality is important in historical and contemporary theatrical works both well-known and obscure. In Edward Albee's *Who's Afraid of Virginia Woolf?* smoking is an integral behavior of the character Martha. Hal Holbrook's one-man show *Mark Twain Tonight!* includes a cigar-puffing portrayal of Mark Twain, whose gruff, boisterous personality would be unrecognizable without a lit cigar in hand. In the Pulitzer prize-winning play, *Anna in the Tropics*, the ethos of the play's locale, a Tampa cigar factory in the late 1920s, comes alive with the visual element that wreaths of cigar smoke imbue to a darkened stage. Cigars are central to the characters' livelihood and culture.

Among TCG's membership is The Public Theater on Lafayette Street, which also presents performances at the Delacorte Theatre in Central Park. The Public also, from time to time, performs in other parks around the City, as do other theatre companies.

TCG's member theatres, in accordance with the indoor smoking ban already in place, most regularly use herbal cigarettes in performances where smoking is called for by the playwright or the director. But, there are occasions in which a regular cigarette or a cigar may be called for. I understand it is difficult and/or expensive to find herbal cigars. Therefore, in the interest of freedom of expression and artistic expression, TCG requests that new legislation aimed at banning outdoor smoking, provide some provision for a theatre company to apply for an exemption or a waiver for tobacco products for a particular performance.

I also just want to take this opportunity to acknowledge the support that TCG received from the NYC Department of Cultural Affairs for our national Free Night of Theatre Program, which is currently underway.
Thank you.

Good afternoon and thank you for allowing me to testify on the important issue of smoke-free parks and beaches in New York City.

My name is Warren Schreiber and it is my honor to serve as president of The Bay Terrace Community Alliance, a neighborhood coalition of concerned citizens committed to preserving our quality of life.

Formed in 1999, the Bay Terrace Community Alliance (BTCA) now represents 5,000 households in Northeast Queens. The BTCA was one of the first groups to advocate for smoke-free parks and beaches in New York City.

City Council Intro 332-2010, Prohibiting smoking in pedestrian plazas and public parks, does not violate anyone's rights or freedom. To the contrary, it restores our right to breathe fresh air when using parks or beaches.

Parks, green spaces and beaches are where children, senior citizens and young families go to experience fresh air, a clean, healthy environment and a natural habitat. For many individuals parks and beaches represent an oasis where they can escape and relax for a few hours. Tobacco smoke is not fresh, not clean, not healthy and definitely not natural.

Some people claim that smoke-free parks are an extension of the "nanny state." The dictionary defines nanny as someone who cares for children and protecting our children is a large part of what intro 322 is about. According to the Centers for Disease Control and Prevention, almost 90% of smokers started smoking before the age of 20, and the average initiation age is 14 1/2 years old. Each day in the United States, approximately 3,900 young people between 12 and 17 years of age smoke their first cigarette, and an estimated 1,000 youth become daily cigarette smokers. It is our responsibility as a society to help role model non-smoking behavior to children and youth and to provide children, youth and their families with a safe, smoke-free environment.

I urge the City Council to pass intro 322 without any exclusions or amendments, which would designate selected portions of our parks or beaches as smoking areas.

****

Warren Schreiber
President, Bay Terrace Community Alliance

13-24 Bell Blvd.
Bayside, NY 11360
917-494-2247
warrennyc@gmail.com

PLEASE, A HEARTFELT PLEA TO MAKE LIFE A LITTLE MORE PLEASANT FOR THE NON-SMOKERS OF THIS CITY

This is a quality of life issue. Smoking is unique amongst all other personal indulgences, in that IT DIRECTLY IMPACTS OTHER PEOPLE, NOT JUST THE SMOKER HIM/HERSELF. Smokers force non-smokers in their immediate vicinity to become, in effect, "smokers" as well, because the latter are forced to inhale the second-hand smoke of the former (unless they hold their breath each time they pass a smoker—perhaps smokers suggest they do that?). Second-hand smoke has been scientifically determined to be injurious to the health of non-smokers (see Publication of the Surgeon General I am holding, + the booklet I have distributed). Personally, I don't understand why smoking in public is not banned, period. Smoking is an obnoxious, offensive, vile, gross, nasty, odious, disgusting habit. Someone once said, in an attempt to explain the limits of personal freedom, that your right to swing your arm ends at the tip of my nose. Smokers literally ASSAULT AND BATTER the non-smokers they come into contact with on the streets. If we are to believe the information put out to the public, non-smokers outnumber smokers 4 to 1. I thought this country was based on "majority rules". NON-SMOKERS HAVE RIGHTS TOO, AND IT'S TIME OUR RIGHTS WERE TAKEN INTO ACCOUNT. WE HAVE THE RIGHT TO BREATHE CLEAN, FRESH AIR, AS GOD OR MOTHER NATURE INTENDED. WE HAVE THE RIGHT NOT TO BE ASSAULTED AND BATTERED BY CIGARETTE SMOKE. Smokers are drug (nicotine) addicts. I don't understand why they are allowed to indulge their drug habit openly and brazenly, with impunity, as well as allowed to set a very deleterious example for children who view them, by being allowed to smoke in public. Smokers who have children and pets are subjecting them to serious health risks, as well as making the air they breathe extremely odious. They are also poisoning plants, flowers, birds, animals, and insects by pouring carcinogens into the air. Where is PETA on this issue? Why are they silent? There are alternatives to smoking cigarettes in order to deliver nicotine to these addicts, including nicotine lozenges, patches, gum, laser treatments, and "e-cigarettes". Personally, if they are aware that they are "addicted", I think they should voluntarily go to some sort of "rehab" in order to break their habit. The burning end of the cigarette, as well as the exhalations of the smokers, are extremely offensive in terms of the foul odors they give off. In short, the smell of the "second-hand smoke" STINKS! I become angry and depressed when I go outside each day, hoping to be able to breathe in clean, fresh smelling air, given to us by God or Mother Nature, and by so doing, extract some small pleasure from merely living, and instead am forced to breathe in disgusting, foul-smelling cigarette smoke.

I am very thankful to the Mayor and the City Council for banning smoking in restaurants and bars, which has enabled me to patronize such places and enjoy eating there. I wish smoking were banned from in front of restaurants and bars as well, since often the doors are left open, and the smoke wafts in from the smokers smoking directly in front of the restaurants/bars. The distance that smokers should have to maintain, from in front of restaurants and bars, should be increased so as to prevent the smoke from entering the restaurant. I hope that you will continue to take the rights of non-smokers into account and ban smoking in parks, beaches, and public plazas, as the next step in eventually banning smoking in public, period. Currently, if I want to go to the beach, I am forced to find a beach where there are virtually no other people around. I am forced to go to the end of the Coney Island beach, near Sea Gate, for example, where even there I often cannot find an escape from smokers. I have stopped, completely, my custom of walking on the Boardwalk, for pleasure, due to the numerous smokers there. When I used to frequent Marine Park, to jog, I was forced to breathe in the second-hand smoke from smokers there, which made my experience unpleasant, and, frankly, infuriating. I see no reason why smokers cannot indulge their habit in the privacy of their own homes, or in their cars, as a compromise to the non-smokers. I think smokers who refuse to understand their effect on non-smokers are being EXTREMELY INCONSIDERATE AND SELFISH. In addition, if we are to believe what the environmentalists and anti-global warming advocates tell us about carbon and toxins, cigarette smoke is a pollutant to the atmosphere, and a contributor to global warming. I would hope and expect that all such people would be behind this effort to limit smoking in public, although I find it curious that, to date, they have been strangely silent on this issue. Smoking serves no necessary purpose to society, except possibly as an anti-depressant or an anti-anxiety agent, in which case psychiatrists could prescribe medication (nicotine) in pill form as an alternative for smokers, which would not impact on non-smokers, as cigarettes currently do.

THANK YOU FOR HAVING CONSIDERATION FOR THE RIGHTS OF NON-SMOKERS

A CONSTITUENT OF COUNCILMAN MIKE NELSON.

Testimony of Ronald Melendi, President
New York Tobacconist's Association
October 14, 2010
Before the Joint Meeting of the New York City Council
Committee on Health and Committee on Parks and Recreation

My name is Ron Melendi, a certified master tobacconist, president of the New York Tobacconist's Association and general manager of De La Concha; a professional tobacconist in mid-town Manhattan and I come before you today to educate and explain why the proposed ban to eliminate smoking in the parks and beaches as well as the pedestrian plazas is flawed and will not accomplish your goals.

As the president of the New York Tobacconist's Association I represent about 50 Professional Tobacconist's in New York City and hundreds more in upstate and Long Island. Which together employee a few thousand people who also have families and many with children; the threat to these small businesses will reach these families as a result of this law. I am also a Certified Master Tobacconist from Tobacconist University, as well as a Professional Tobacconist and a American.

As I mentioned above the proposed bill is flawed:

1.) The bill is based on junk science. There is no conclusive scientific evidence that second hand smoke in wide open spaces presents any health hazard. As a matter of fact the amount of toxic chemicals in the air is mainly from car and truck exhaust. According to the Book Air and Breathing by Dr. Stephen Gislason M.D. "Driving a car is the most air polluting act an average citizen commits" not only are their local effects such as poisoning humans breathing the bad air but this air contains the following pathogens from the toxic car and truck exhaust:
    a.) Carbon Monoxide
    b.) Nitrogen Dioxide
    c.) Sulphur Dioxide
    d.) Suspended Particles less than 10 microns which are inhaled into the lungs.
    e.) Benzene
    f.) Formaldehyde
    g.) Polycyclic Hydrocarbons

Let me also remind the committee that on a given day there are tens of thousands if not hundreds of thousand of cars and automobiles on our streets which is far greater than the numbers of smokers. If health is really the issue then you would have no choice but to ban cars and trucks inside the city and we all know that this is not going to happen.

2.) Why would the city want to move a smoker from the wide open space of a park and bring them back into the city streets where it is more congested. This is nothing more than a planned agenda, a litmus test, to eventually ban smoking on the sidewalks because of increased smoking on the sidewalks of our city streets.

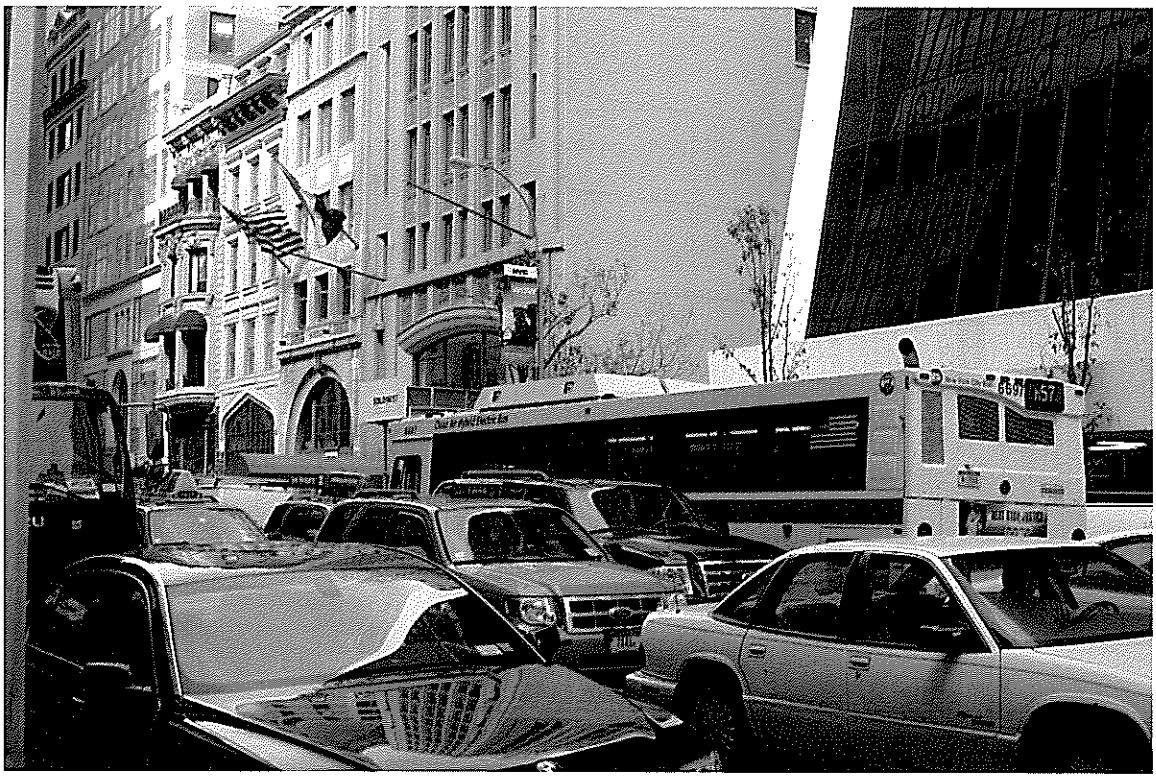
3.) The park or open space is so large that why would a non-smoker even need to come anywhere near a smoker. This is common sense.

A.) A wide open path in Central Park

B.) Wide open Grassy Area in Central Park

C.) Traffic in New York City

D.) Car and Bus Exhaust poisoning New Yorkers



E.) A Crowded New York City Sidewalk

4.) Their has been talk that because of littering on the beaches smoking should be banned their as well. Once again we have a situation of this bill being flawed. There are already laws on the books for littering; you discard anything on the ground you face a possible fine. Period.

5.) Their is also the issue of enforcement. Do we really want the NYPD who are already stressed out wasting time and resources writing out tickets when they should be focusing on real crimes; just over the summer someone tried to blow up time square, the last thing we need is a police officer worrying about giving a ticket for smoking while ignoring a serious crime because his attention was on writing this summons.

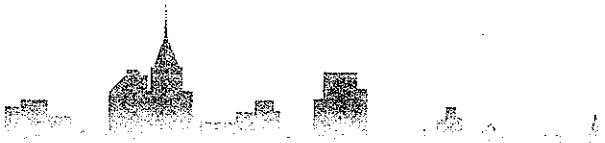
As you can see this has nothing to do with health and everything to do with the fact that you don't want anyone to be seen smoking out in public. Laws that are based on emotion are laws that not only fail outright but these laws represent a government that does not serve its people but rather its own agenda. This harassment, persecution, and discrimination to our businesses and rights has to stop. Enough is Enough!

I find it downright despicable that our own New York City Government has nothing better to do than come up with laws that are really disguised as " Prohibition through Increments". We need to get New York working again; the city should be finding ways to put people back to work not pass laws which take jobs and basic rights away. That's right jobs; why? You ask, because I am one of about 50 Professional Tobacconists in the city limits and this is the type of law that will further hurt my business. We already have one of the highest tobacco taxes in the country (In one years time it went from 46% to 75%), a ban on flavored tobacco (What about flavored alcohol which is much more dangerous but totally ignored by the mayor and the city council) , signage regulation (which serves no purpose except to deface our tobacco shops and give the city free advertising) as well as other tightly controlled laws surrounding tobacco.

I have been in this business for over 25 years and my family has been in this business for over 100 years and as a Cuban-American laws such as these effect my livelihood, passion and family heritage. The job of government is to protect the people, all the people not just a segment of the people. The laws that are passed should be fair and balanced, this is apparently not.

According to Dr Michael Siegal from Boston University: "There seems to be a disconnect behind the scientific data being cited and the actual proposal. The argument of this bill does not extend to wide open areas like Central Park and hundreds of other large parks in New York City where there is plenty of room for nonsmokers to walk away from someone who is smoking if they wish to avoid the exposure."

New York City is like a small country and millions of tourists visit each year some of which believe or not enjoy taking time out to smoke. The city has already closed down access to smoking almost in all indoor locations so to restrict access to the outdoors is not the right move. The whole purpose of the indoor smoke act was because the non-smoking public couldn't easily get away from the smoke. Smoking outdoors is not the same thing and I urge all the members of the city council to do the right thing and vote against this bill. Thank You.



NYC
COALITION FOR A
smoke-free
city

Bronx Smoke-Free Partnership
Brooklyn Smoke-Free Partnership
Manhattan Smoke-Free Partnership
Queens Smoke-Free Partnership
Staten Island Smoke-Free Partnership

Testimony of

Sheelah Feinberg

Director

New York City Coalition for a Smoke-Free City

before the

New York City Council Committees on Health and Committee on Parks and Recreation

October 14, 2010

Regarding Intro 332 of 2010

New York City Council Hearing Room
250 Broadway, 14th Floor
New York, NY 10007

Good afternoon. My name is Sheelah Feinberg and I am the Director of the New York City Coalition for a Smoke-Free City. The Coalition, for the past ten years and counting, has been dedicated to raising public and policymaker awareness of the harmful impacts of smoking and secondhand smoke. Beginning with the campaign to pass New York City's *Smoke Free Air Act,* and more recently with the ban on flavored tobacco products, the Coalition has worked alongside with many community and non-profit partners to promote smoke-free policies.

Today, I want to thank Council Member Brewer for introducing Intro 332 and the twelve Council Members who are current co-sponsors. I am pleased to provide testimony in support of Intro 332, which would be a complete ban on smoking in all of New York City's public parks, pedestrian plazas and beaches. The Coalition does not support policy that would allow smoking in some parts of parks and beaches; therefore I am here to speak only in support of Council Member Brewer's bill. I am equally pleased to be joined by more than 20 health, environmental, and community advocates from all five boroughs expressing their support for Intro 332.

Since the passage of the *Smoke-Free Air Act,* we have learned that the health risks of exposure to secondhand smoke outdoors are similar to the risks indoors within a certain proximity.[1] There is no safe level of exposure to secondhand smoke, and even relatively short periods of breathing the carcinogens and toxins found in secondhand smoke can increase risk of blood clots and lead to more frequent asthma attacks.[2]

The implementation of smoke-free policies, taxes on cigarette sales, hard-hitting media campaigns, and providing cessation services to help smokers quit, has reduced the prevalence of smoking in New York. These lower smoking rates mean thousands of lives saved, increased life expectancy, and improved health for all New Yorkers. Hundreds of thousands of New Yorkers have quit smoking since the implementation of the *Smoke Free Air Act,* many utilizing 3-1-1 or the New York State Quit line. However, too many people are still battling physical addictions to cigarettes, many of which begin at a young age. New York youth will smoke 35.5 million packs

---

1 Klepeis N.E., Ott W.R., and Switzer P. (2007) "Real-Time Measurement of Outdoor Tobacco Smoke Particles," *Journal of the Air and Waste Management Association,* 57:522-534.
2 Ellis JA, Gwynn C, Garg RK, Philburn R, Aldous KM, Perl SB, Thorpe L, Frieden TR. Secondhand smoke exposure among nonsmokers nationally and in New York City. Nicotine Tob Res. 2009 Apr;11(4):362-70. Epub 2009 Apr 7.

of cigarettes this year[3] and over 20,000 New York kids will become addicted daily smokers - 1/3 of them will die prematurely from tobacco-related illness.[4] Furthermore, several studies have found that parental smoking, especially more exposure to parental smoking increases the likelihood of adolescent smoking in their children. This policy would help address this by not allowing smoking in parks or ball fields, where many kids enjoy playing sports. [5]

There is still much more work to do as smoking still kills more New Yorkers than AIDS, homicide, suicide, and drug use combined[6] and the Center for Disease Control ranks tobacco use as the number one preventable cause of disease, disability, and death in the United States.[7] Even with non-smoking policies in place, more than half of non-smoking New Yorkers still (57%) have elevated levels of cotinine, a by-product of nicotine in their blood. This results from exposure to toxic secondhand smoke in concentrations high enough to leave residues in the body.

Cigarettes hurt our environment. 75% of litter found on New York City beaches is discarded cigarette butts which are toxic, slow to decompose, and costly to manage.[8] We also know that the health care costs incurred by smoking related diseases are immense. New York spends over $8 billion annually on health care directly related to tobacco use, and the State's Medicaid Program incurs $5.4 billion annually in tobacco-related expenses.[9] The burden is passed along to tax-paying families as these enormous expenses break down to an annual cost of $900 per household.

---

[3] Campaign For Tobacco Free Kids (CTFK), Fact Sheet: The Toll of Tobacco in New York, September 21, 2009

4 Sustained Anti-Tobacco Initiatives Cut Teen Smoking by More Than Half Over Six Yeats...DOHMH January 2, 2008 Press Release #001-08 Retrieved from http://www.nyc.gov/html/doh/html/pr2008/pr001-08.shtml

[5] Gilman, SE, et al., "Parental Smoking and Adolescent Smoking Initiation: An Intergenerational Perspective on Tobacco Control," *Pediatrics* 123(2): e274-e281, February 2009. Jackson, C, et al., "Do as I say: parent smoking, antismoking socialization, and smoking onset among children," *Addictive Behaviors* 22(1):107-14, January-February 1997

[6] Department of Health and Mental Hygiene, "Summary of Vital Statistics 2008". Bureau of Vital Statistics 2008

7 CDC, Tobacco Use At a Glance 2010: http://www.cdc.gov/chronicdisease/resources/publications/aag/pdf/2010/tobacco_2010.pdf

8 New York City Department of Parks and Recreation and New York City Department of Health and Mental Hygiene small-scale survey of cigarette-related litter items in NYC parks, beaches and playgrounds, summer 2010.

9 Zhang, X., et al., "Cost of Smoking to the Medicare Program, 1993

When New York City passed the Smoke-Free Air Act, we were considered a public health pioneer. Contrary to the many skeptics at the time, restaurants and bars have not closed; instead the nightlife and tourism industry have flourished. New York City now has the opportunity to follow the lead of forty-four other counties in New York State that have adopted smoke-free policies for parks and/or beaches. Nationally, big cities such as Chicago, Los Angeles, and Seattle have also made their public parks smoke-free, because they too are recognizing the positive health and environmental impacts of smoke free parks and beaches.

Closer to home, the Coalition is currently working in each borough meeting with elected officials, community boards, and community based organizations to build support for good public health policies, to educate the public of the dangers of smoking and secondhand smoke, and to link groups and individuals to cessation resources.

We strongly support Intro 332 and other policy that reduces the exposure to secondhand smoke, protects our kids from smoking, and helps current smokers break free of the addiction to a deadly, harmful product.

Thank you.

JOE ROWE
Executive Director

Gary Pesh, *President*
Curt Diebel, *First Vice President*
Finnie Helmuth, *Second Vice President*
Craig Cass, *Treasurer*
Ken Neumann, *Secretary*

Tom Moran, *President Ex-Officio*

International Premium Cigar & Pipe Retailers Association
IPCPR

#4 Bradley Park Court Suite 2H
Columbus, Georgia 31904-3637

Phone: 706-494-1143
Fax: 706-494-1893
website: www.ipcpr.org
email:info@ipcpr.org,

Testimony of Joe Rowe the Executive Director of the International Premium Cigar & Pipe Retailers Association before the Joint Committee Hearing of the Commissions of Parks and Recreation and Public Health, October 13, 2010

Good afternoon ladies and gentlemen and thank you for the opportunity to present comments, on behalf of our member companies, on the proposed legislation to amend the administrative code of the city of New York in relation to prohibiting smoking in pedestrian plazas and public parks

My name is Joe Rowe, and I am the Executive Director of the International Premium Cigar & Pipe Retailers Association (IPCPR) The IPCPR in its Seventy Eight (78) year of continuous operation is a not-for-profit trade association incorporated in the state of New York and represents premium, professional tobacconists in New York and around the world.

I am not here to tell you that smoking is good for you, as you would certainly laugh me out of the room, but to speak to the issue of second-hand smoke (SHS) which is clearly the basis for this potential legislation.

I have included with my written testimony three (3) enclosures:

- **A paper by the noted pulmonologist Dr. Jerome Arnett, Jr titled *The Emperor Has No Clothes: The Truth About Secondhand Smoke***
- **The twenty seven (27) page *Executive Summary* of the 2006 Surgeon General's report; *The Health Consequences of Involuntary Exposure to Tobacco Smoke* with a cover analysis by the IPCPR's legislative director, Chris McCalla. Please note that this is not selected sections of the *Executive Summary* but the full *Executive Summary* verbatim**
- **A paper titled *Clearing the Haze* by Michael R. Pakko, an economist at the Federal Reserve Bank of St. Louis**

In Dr Arnett's paper he speaks to the fact that exposure to secondhand smoke (SHS) is an unpleasant experience for many non-smokers and for decades was considered merely a nuisance. The idea that it might actually cause disease in non-smokers had been around since the 1970s and recent surveys show that more than 80% of Americans now believe it is harmful to non-smokers

But what are the facts.

The 1972 Surgeon General's report first addressed passive smoking as a possible threat to non-smokers. The problem was addressed again in the 1979, 1982 and 1984 Surgeon General's Reports. The 1986 Report concluded that involuntary smoking caused lung cancer but offered only weak epidemiologic evidence. So in 1989 the Environmental Protection Agency (EPA) was charged with further evidence for health effects of SHS
In 1992 the EPA published its report, *Respiratory Health Effects of Passive Smoking,* which claimed that SHS is a serious public-health problem. The report has been used by the tobacco-control movement and government agencies, including public health departments, to justify the imposition of thousands of indoor smoking bans in public places. But the report's conclusions are not supported by reliable scientific evidence. It has largely been discredited and in 1998, was legally vacated by Federal Judge William Osteen

who in a 92-page opinion stated he found a culture of arrogance, deception and cover-up at the agency. He noted, "First, there is evidence in the record supporting the accusation that EPA "cherry picked" its data In order to confirm its hypotheses. And, "EPA publicly committed to a conclusion before the research had begun; adjusted established procedure and scientific norms to validate its conclusion; and aggressively utilized its authority to disseminate finding to establish a *de facto* regulatory scheme to influence public opinion".

Dr Arnett concludes, "The abuse of scientific integrity and the generation of faulty "scientific" outcomes (through the use of pseudo-science) have led to deception of the American public on a grand scale, and to draconian government over-regulation and the squandering of public monies." Finally, all this has denied personal choice and freedom to millions of smokers and diverted resources away from discovering the true cause(s) of lung cancer in non-smokers.

Now, let us address the 2006 Surgeon General's Report

The 2006 Surgeon General's Report and its accompanying Executive Summary clearly show that second-hand smoke should not be considered a legitimate health or environmental hazard. Media reports, statements made by anti-tobacco groups and even press releases from the Surgeon General's office contradict the actual findings of the Report

The Executive Summary was reviewed and the following points lead to the conclusion that this latest Surgeon General's report, like those previously issued, is inconclusive in its claims regarding second-hand smoke, contrary to information reported by the media and anti-tobacco groups

In analyzing both the *Executive Summary (ES)* and *Full Report* it is imperative to note that, much of the research proves to be inconclusive. Two key phrases are used throughout both reports that call attention the inconclusive results of their research:

Phrase One: "The evidence is inadequate to [infer, suggest, or relate various health issues to second-hand smoke]

This phrase appears 17 times in the *ES* and 52 times in the *Full Report*

Phrase Two: "The evidence is suggestive but not sufficient to [infer, suggest, or relate various health issues to second-hand smoke]

This phrase appears 19 times in the *ES* and 56 times in the *Full Report*

We have taken the liberty to highlight those phrases in your copies and you will see a bunch of highlights

The third enclosure deals with economic impact of smoking restrictions and what the IPCPR believes will be the unintended consequences of this legislation should it pass into law.

Our members businesses will be negatively impacted by further restricting where the cigar and pipe smokers of this city can use and enjoy the legal products which are of choice and not habit. The professional tobacconists of New York have been pummeled by excessive taxation and smoking restrictions and their very livelihood is at stake. Passage of this law would be one more step in escalating the probability that our members will go out of business.

Our members, many generational businesses, are proud contributing members of their community where they live and work. Our members employ over 200 full and part time employees and generate over $ 2.3 million dollars in sales tax generation for the city and significant additional state revenue in business and personal taxes.

We ask you to give careful consideration to the reasons for and the unintended consequences of this potential legislation.

THE EMPEROR HAS NO CLOTHES:
THE TRUTH ABOUT SECONDHAND SMOKE

Exposure to secondhand smoke (SHS) is an unpleasant experience for many nonsmokers and for decades was considered merely a nuisance. The idea that it might actually cause disease in nonsmokers has been around since the 1970s, and recent surveys show that more than 80% of Americans now believe it is harmful to nonsmokers.[1,2]

The 1972 Surgeon General's report first addressed passive smoking as a possible threat to non-smokers and called for an anti-smoking movement.[3] The problem was addressed again in the 1979, 1982, and 1984 Surgeon General's Reports. The 1986 Report concluded that involuntary smoking caused lung cancer but offered only weak epidemiological evidence to support the claim.[4] So in 1989, the Environmental Protection Agency (EPA) was charged with further evaluating the evidence for health effects of SHS.

Three years later, in 1992, EPA published its report, "Respiratory Health Effects of Passive Smoking," which claimed that SHS is a serious public-health problem, that it kills approximately 3,000 nonsmoking Americans each year from lung cancer, and that it is a Group A carcinogen (similar to benzene, asbestos, and radon).[5] The report has been used by the tobacco-control movement and government agencies, including public-health departments, to justify the imposition of thousands of indoor smoking bans in public places. But the report's conclusions are not supported by reliable scientific evidence. It has been largely discredited and, in 1998, was legally vacated by a federal judge. Even so, it was cited in the Surgeon General's 2006 report on SHS, where then-Surgeon General Richard Carmona made the absurd claim that there is no risk-free level of exposure to SHS.[6]

With its 1992 report, the EPA arbitrarily chose to equate SHS with mainstream (or firsthand) smoke. One of the agency's stated assumptions was that because there is an association between active smoking and lung cancer, there also must be a similar association between SHS and lung cancer. But SHS is not a single entity that can be measured or even precisely defined. Documenting actual exposure has never been possible. That's why only indirect estimates have been used—primarily, exposure to spousal smoking. And, after hundreds of millions of dollars of research over more than two decades, no specific carcinogen in smoke has ever been established as the causal agent.

In addition, the problem posed by SHS is entirely different from that found with mainstream smoke. A well recognized toxicological principle is, "the dose makes the poison." We physicians record direct exposure to cigarette smoke by smokers in the medical record as 'pack-years smoked' (packs smoked per day times the number of years smoked). A smoking history of around ten pack-years alerts the physician to search for cigarette-caused illness. But even those nonsmokers with the greatest exposure to SHS probably inhale the equivalent of only a small fraction (around 0.03) of one cigarette per day, which is equivalent to smoking around 10 cigarettes *per year*.[7,8]

Another major problem is that the epidemiological studies on which the EPA report is based are statistical studies that can only show correlation but cannot prove causation. One statistical method used to compare the rates of a disease in two populations is relative risk (RR). It is the rate of disease found in the exposed population divided by the rate found in the unexposed population. A RR of 1.0 represents zero increased risk. Because confounding and other factors can obscure a weak association, in order to *suggest* causation a very strong association must be found, on the order of at least 300% to 400%, which is a RR of 3.0 to 4.0.[9] For example, the studies that linked direct cigarette smoking with lung cancer found an incidence

in smokers of twenty to around forty times that in non-smokers (an association of around 2000% to 4000%, or a RR of around 20.0 to 40.0).[10]

An even greater problem is the agency's lowering of the confidence interval (CI) used in its report. Epidemiologists calculate confidence intervals to express the likelihood that a result could happen just by chance. A CI of 95% allows a 5% possibility that the results occurred only by chance. Before its 1992 report, the EPA had always used epidemiology's gold standard CI of 95% to measure statistical significance. But because the US studies that were chosen for the report weren't statistically significant with a 95% CI, for the first time in its history the EPA changed the rules and used a 90% CI, which doubled the chance of being wrong. This allowed it to report a statistically significant 19% increase of lung cancer cases in non-smoking spouses of smokers over those cases found in non-smoking spouses of non-smokers. Even though the RR was only 1.19 the agency concluded this was proof that SHS increased the risk of US nonsmokers developing lung cancer by 19%.

In November 1995, after a 20-month study, the Congressional Research Service released a detailed analysis of the EPA report that was highly critical of EPA's methods and conclusions.[11] In 1998, in a devastating 92-page opinion, Federal Judge William Osteen vacated the EPA study, declaring it null and void.[12] He found a culture of arrogance, deception, and cover-up at the agency. He noted, "First, there is evidence in the record supporting the accusation that EPA "cherry picked" its data...In order to confirm its hypothesis, EPA maintained its standard significance level but lowered the confidence interval to 90%. This allowed EPA to confirm its hypothesis by finding a relative risk of 1.19, albeit a very weak association...EPA cannot show a statistically significant association between [SHS] and lung cancer." And, "EPA publicly committed to a conclusion before the research had begun; adjusted established procedure and scientific norms to validate its conclusion; and aggressively utilized its authority to disseminate findings to establish a *de facto* regulatory scheme to influence public opinion."

Several years later, in 2003, a definitive paper on SHS and lung cancer mortality was published in the British Medical Journal by Enstrom and Kabat.[13] It is the largest and most detailed ever reported. The authors studied more than 35,000 California never smokers over a 39-year period and found no statistically significant association between exposure to SHS and lung cancer mortality.

The 1992 EPA report is an example of the use of epidemiology to promote an epidemic rather than to investigate one. It has damaged the credibility of the EPA and has tainted the fields of epidemiology and public health. In addition, influential anti-tobacco activists, including prominent academics, have unethically attacked the research of eminent scientists, such as Dr. James E. Enstrom of UCLA's School of Public Health and Dr. Michael Siegel of Boston University's School of Public Health, in order to further their ideological and political agendas.[14,15]

The abuse of scientific integrity and the generation of faulty "scientific" outcomes (through the use of pseudo-science) have led to deception of the American public on a grand scale, and to draconian government over-regulation and the squandering of public monies. Millions of dollars have been spent promoting SHS as a killer and more millions of dollars have been spent by businesses in order to comply with thousands of highly restrictive bans, while personal choice and freedom have been denied to millions of smokers. Finally, all this has diverted resources away from discovering the true cause(s) of lung cancer in non-smokers.

Jerome Arnett, Jr. M.D.

Dr. Arnett is a pulmonologist who lives in Helvetia, WV.

[1] Texas Department of State. Health Services. *Most Respondents to Texas BRFSS Survey favor Protection from Second Hand Smoke in Public Places*. [http://www.dshs.state.tx.us/chs/brfss/Reports/smokban.shtm].
[2] Access Washington. Kittitas County Public Health. *Exposure to Second Hand Smoke Survey. Results of the 2004 Survey*. [http://www.co.Kittitas.wa.us/health/toacco/shs004.asp].
[3] U.S. Public Health Service. Office of the Surgeon General. 1972. Atlanta, Ga.: *The Health Consequences of Smoking: A Report of the Surgeon General*. [http://profiles.nlm.nih.gov/NN/B/B/P/M/_/nnbbpm.pdf].
[4] U.S. Public Health Service. Office of the Surgeon General. 1986. Atlanta, Ga.: *The Health Consequences of Involuntary Smoking: A Report of the Surgeon General*. [http://profiles.nlm.nih.gov/NN/B/C/P/M/_/nnbcpm.pdf].
[5] U.S. Environmental Protection Agency. *Respiratory Health Effects of Passive Smoking: Lung Cancer and Other Disorders: The Report of the Environmental Protection Agency*, EPA/600/6-90/006F, December 1992 [http://cfpub.epa.gov/ncea/cfm/recordisplay.cfm?deid=2835] or [http://heartland.temp.siteexecutive.com/pdf/16667.PDF].
[6] U.S. Department of Health and Human Services. *The Health Consequences of Involuntary Exposure to Tobacco Smoke: A Report of the Surgeon General*. Atlanta, GA: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, Office on Smoking and Health, June 27, 2006 [http://surgeongeneral.gov/library/secondhandsmoke/report/fullreport.pdf].
[7] Hinds WC, first MW. Concentrations of nicotine and tobacco smoke in public places. *N Eng J Med.* 1975 April 17;292(16):844-5 [http://legacy.library.ucsf.edu/tid/lrr57a00/pdf].
[8] Phillips K, Howard DA, Bentley MC, Alvan G. Measure exposures by personal monitoring for respirable suspended particles and environmental tobacco smoke of housewives and office workers resident in Bremen, Germany. Int Arch Occup Environ Health. 1998;71:201-12 [http://legacy.library.ucsf.edu/tid/zdh67e00/pdf].
9 Taubes G. Epidemiology Faces Its' Limits. *Science* 1995;268:164-9 [http://legacy.library.ucsf.edu/tid/ftv34a00/pdf].
10 Doll R, Hill AB. "Lung cancer and other causes of death in relation to smoking: A second report on the mortality of British doctors. *BMJ* 1956;2:1071-81 [http://legacy.library.ucsf.edu/tid/fmk92f00/pdf].
11 Redhead CS, Rowberg RE. *Congressional Research Service Report for Congress. Environmental Tobacco Smoke and Lung Cancer Death Risk.* Congressional Research Service 95-1115, November 14, 1995 [http://legacy.library.ucsf.edu/tid/eyk0lc00/pdf].
[12] Osteen WL. Order and Judgment. *Flue-Cured Tobacco Cooperative Stabilization Corporation et al. V. United States Environmental Protection Agency, and Carol Browner, Administrator,* Environmental *Protection Agency.* U.S. District Court, Middle District of North Carolina. Winston-Salem Division, Decision 6:93CV00370, July 17, 1998 [www.junkscience.com/news2/osteen.htm].
[13] Enstrom JE, Kabat GC. Environmental tobacco smoke and tobacco related mortality in a prospective study of Californians during 1960-98. *BMJ* 2003;326:1057-61 [http://bmj.com/cgi/reprint/326/7398/1057.pdf].
[14,] Enstrom JE. Defending legitimate epidemiologic research: combating Lysenko pseudoscience. *Epidemiol Perspect & Innov.* 2007;4:11 [http://www.epi-perspectives.com/content/4/1/11].
[15] Phillips CV. Warning: Anti-tobacco activism may be hazardous to epidemiologic science. *Epidemiol Perspect & Innov.* 2007;4:13 [http://www.epi-perspectives.com/content/pdf/1742-5573-4-13.pdf].

Clearing the Haze?

New Evidence on the Economic Impact of Smoking Bans

By Michael R. Pakko

When making decisions about adopting smoke-free laws, advocates often give policymakers a Pollyannaish outlook in which communities can achieve public health benefits with no economic consequences. In particular, the lack of statistically significant economic effects is interpreted as indicating an absence of economic costs. Recent economic research indicates that this is a far too simplistic view of the issue.

A previous article in *The Regional Economist* ("Peering Through the Haze," July 2005) described some early evidence on the economic impact of smoke-free laws and suggested that the findings were far from conclusive.[1]

As more communities have adopted smoke-free laws and more data have been gathered, economists have discovered new, significant findings. As an earlier article suggested, economic costs often focus on specific business categories—those that smokers tend to frequent.

Gambling and Smoking

Several papers have examined the cost of smoke-free laws on the gambling business, using data from slot machine revenue at Delaware racetracks ("racinos").[2] Recent economic research finds conclusive evidence of revenue declines at the racinos after the Delaware Clean Indoor Air Law took effect in December 2002.

In my recent research on the topic, I find statistically significant losses at all three Delaware racinos—ranging from 8.9 percent to 17.8 percent.[3] Overall, the statewide revenue decline was 14.9 percent. Using slightly different methods that estimate demand for casino gambling, economists Richard Thalheimer and Mukhtar Ali estimate the total revenue loss at 15.9 percent.

These revenue estimates may significantly understate profit losses. For example, the racino that suffered the smallest loss in revenues—Dover Downs—also was the only one with a luxury hotel on site. Dover Downs management responded to initial revenue losses by offering more discounts on hotel rooms.[4] Efforts to prop up revenue may have been partly successful, but at a cost to the bottom line.

Evidence on the effect of smoking bans on gaming revenue shows that when analysis can be narrowly focused on data from specific businesses, statistically significant findings emerge. Another approach is to use very large data sets. As smoking bans have spread across the country, the variety and timing of adopting smoke-free laws have generated data that can help identify effects.

Bar and Restaurant Employment

Two papers, one by Ryan Phelps and the other by Scott Adams and Chad Cotti, have used data available from the Bureau of Labor Statistics to examine the employment effects of smoking bans. Using nationwide county-level data, these two studies examine the changes in employment at bars and restaurants after communities adopt smoking bans. Neither study finds significant employment changes at restaurants, on average, but both find statistically significant employment declines at bars, with loss estimates ranging from 4 percent to 16 percent.

Adams and Cotti also examine some additional factors. For communities in states with a higher ratio of smokers to nonsmokers than the national average, employment losses at bars were significantly larger, and the employment changes at restaurants went from a small positive effect to a small negative effect (in neither case, statistically significant). Climate also affected restaurant employment.[5] Restaurants in warm climates fared better than those in cooler climates. The authors suggest that the reason for this might be that restaurants in warmer climates can more easily provide outdoor seating where smoking is not prohibited. (See also the sidebar on Columbia, Mo.) Restaurants that suffered the dual curse of being in regions with colder climates *and* a high prevalence of smokers suffered statistically significant employment losses, on average.

California Dreamin'

Another recent economic study examines taxable sales receipts of bars and restaurants in California, the home of the smoke-free movement. Because California communities passed some of the nation's first smoke-free laws, much of the early evidence on the subject was based on these data on California taxable sales receipts; as time has passed, those data have accumulated. The experience of California also provides a case in which a statewide smoking ban was superimposed on a patchwork of local smoke-free laws, providing useful variation in the coverage and jurisdiction of smoking bans that can be exploited in empirical analysis.

This article is based on a presentation at the Sixth Annual ERIE Conference on Local Government and Economics, Erie Pa., Aug.14, 2007.

District Focus: Smoking Ban Singes Columbia, Mo.

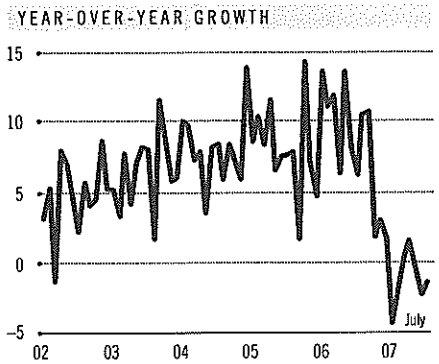
Since January 2007, all bars and restaurants in Columbia, Mo., have been required to be smoke-free. Only some sections of outdoor patios are exempt from the requirement.

Some local businesses have continued to oppose the Columbia Clean Air Ordinance, circulating petitions to repeal the law by ballot initiative. According to local press reports, owners of at least four establishments have cited the smoking ban as a factor in their decision to close their doors in 2007.

Recent data from the city of Columbia show a distinct decline in sales tax receipts at bars and restaurants. After rising at an average rate of 6.8 percent from 2002 through 2006, tax revenue declined at an annual rate of 1.3 percent over the first seven months of 2007. (See graph.) Although the data are still preliminary, initial analysis suggests a 5 percent decline in overall sales revenue at Columbia dining establishments since the implementation of the smoking ban. This estimate takes into account past trends, seasonal fluctuations in the data and an overall slowdown in sales tax revenue in Columbia.[6]

One interesting feature of the Columbia story is the response of restaurant owners to the patio exemption. According to an article in the *Columbia Missourian*, owners of at least two bars are building or planning outdoor patio expansions. One owner was quoted as saying, "You have to have a patio to survive."[7] The expenses associated with these renovations may help buffer the sales revenue of these establishments, but they also represent profit losses that are above and beyond the measured sales declines.

Columbia, Mo., Dining Tax Revenue



SOURCES: City of Columbia, Mo., and author's calculations

Economists Robert Fleck and Andrew Hanssen analyzed quarterly restaurant sales data for 267 California cities over 25 years. They find that the measured impact of smoking bans differs between local bans and the statewide ban. In what the authors call their "naïve" specification that treats all smoke-free laws the same, they find a statistically significant 4 percent decline in revenues associated with smoking bans.

When they estimate the effects of the statewide ban and local bans independently, they find that the measured decline in restaurant sales is attributable to the statewide ban on cities without local bans. The measured effect of the statewide ban is nearly 4 percent, and it is statistically significant. The independent effect of local smoking ordinances is estimated to be very small and is not significant. These findings are consistent with the interpretation that locally originated smoking bans have little effect, but smoking bans that are imposed on a community by a higher jurisdiction can have a detrimental economic impact.

Fleck and Hanssen go on to uncover an important specification problem: They find that cities that adopted smoke-free laws were systematically different from those that did not. The authors find that sales growth tends to be a predictor of smoking bans, rather than the other way around. This "reverse causality" calls into question many earlier findings, and it poses problems for using data from California in drawing inferences about the economic impact of smoking bans elsewhere.

The Role of Economic Research

Economic effects of smoke-free laws may be difficult to identify and interpret, but analysis suggests that at least some businesses do suffer costs. When they consider passing smoking bans, policymakers should study evidence both from public health professionals and from economists.

Michael R. Pakko is an economist at the Federal Reserve Bank of St. Louis. To see more of Pakko's work, go to http://research.stlouisfed.org/econ/pakko/index.html.

ENDNOTES

[1] Scollo et al. (2003) provide a review of previous literature, much of which has been published in medical and public health journals.
[2] Previous studies of the Delaware racino case study have been published—and disputed—in the public health journal *Tobacco Control.*
[3] See Pakko (forthcoming).
[4] See Dover Downs (2004).
[5] Bar employment was not significantly affected by climate differences.
[6] See Pakko (2007).
[7] See Solberg (2007).

REFERENCES

Adams, Scott; and Cotti, Chad D. "The Effect of Smoking Bans on Bars and Restaurants: An Analysis of Changes in Employment." *The B.E. Journal of Economic Analysis & Policy:* Vol. 7, Issue 1, Contributions, Article 12. See www.bepress.com/bejeap/vol7/iss1/art12.

See Dover Downs Gaming and Entertainment Inc. *Annual Report for the Fiscal Year ended Dec. 31, 2003* (2004).

Fleck, Robert K.; and Hanssen, F. Andrew. "Why Understanding Smoking Bans is Important for Estimating Their Effects: California's Restaurant Smoking Bans and Restaurant Sales." *Economic Inquiry* (forthcoming).

Pakko, Michael R. "The Economics of Smoking Bans: Peering Through The Haze." *The Regional Economist,* Federal Reserve Bank of St. Louis, July 2005, pp. 12-13.

Pakko, Michael. R. "No Smoking at the Slot Machines: The Effect of Smoke-Free Laws on Gaming Revenues." *Applied Economics* (forthcoming).

Pakko, Michael R. "The Economic Impact of a Smoking Ban in Columbia, Missouri: A Preliminary Analysis of Sales Tax Data." *CRE8* Occasional Report, Dec. 11, 2007. See http://research.stlouisfed.org.regecon/op/CRE8OP-2007-002.pdf.

Phelps, Ryan. "The Economic Impact of 100% Smoking Bans." *Kentucky Annual Economic Report 2006,* Center for Business and Economic Research, Gatton College of Business and Economics, University of Kentucky, 2006, pp. 31-34.

Thalheimer, Richard; and Ali, Mukhtar M. "The Demand for Casino Gaming with Special Reference to a Smoking Ban." *Economic Inquiry* (forthcoming).

Scollo, M.; Lal, A.; Hyland, A.; and Glantz, S. "Review of the Quality of Studies on the Economic Effects of Smoke-free Policies on the Hospitality Industry." *Tobacco Control,* 2003, Vol. 12, pp. 13-20.

Solberg, Christy. "Effects of Smoking Ban Still Debated." *Columbia Missourian,* Sept. 27, 2007. See www.columbiamissourian.com/stories/2007/09/27/effects-smoking-ban-still-debated/.

American Heart Association. | American Stroke Association.
Learn and Live.

you're the cure.

Testimony of Dr. William Borden
Assistant Professor of Medicine and Public Health, Division of Cardiology,
Weill Medical College of Cornell University
Spokesperson for the American Heart Association / American Stroke Association
122 East 42nd Street, 18th Floor, New York, NY 10168 – 212.878.5922

In Support of Intro 0332-2010

Good afternoon, Chairperson Arroyo, Chairperson Mark-Viverito and members of the New York City Council Committees on Health and Parks and Recreation. My name is Dr. William Borden and I am pleased to serve as a spokesperson today for the American Heart Association / American Stroke Association. We are the largest volunteer organization in the world dedicated to the building of healthier lives, free from heart disease and stroke – the number one and number three causes of death nationally.

I am a preventive cardiologist helping patients to prevent and treat heart disease. As an Assistant Professor of Medicine and Public Health within the Division of Cardiology at Weill Medical College of Cornell University, my goal today is to emphasize that any policy that will motivate people to quit smoking is a valuable public health intervention. I applaud Mayor Bloomberg, Commissioner Farley, Speaker Quinn, Council Member Brewer, and of course both Council Members Arroyo and Mark-Viverito for your leadership in this effort.

The American Heart Association has worked diligently over the past decade, along with our partners in public health, to support strong and effective tobacco control in our city, state and nation. While we consistently seek additional government dollars to support the New York Tobacco Control Program and the City's Bureau of Tobacco Control, several important achievements have been accomplished. The implementation of New York's Clean Indoor Air law was historic and instigated a nationwide momentum that continues to this day. We applaud New York State for having the highest cigarette excise tax in the nation which, coupled with the city's own tax, is motivating New Yorkers to quit their addiction once and for all. Building upon these three proven components of tobacco control that are already in place – an adequately funded tobacco control program, comprehensive clean indoor air and a high excise tax – New York City must now consider additional policy interventions to encourage the remaining 950,000 residents who smoke to grab the reins of their cardiovascular health.

Intro 332, as proposed by Council Member Brewer, will serve several purposes. It will encourage smokers to quit, given that they will have more restrictions regarding where they may light their cigarettes. It will remove the influence of smokers from our residents and children who most actively utilize the parks, beaches and pedestrian plazas. Mayor Bloomberg and Commissioner Farley have outlined the growing body of science that implicates environmental smoke as a hazard to our health. Also, as a private citizen of New York, I am truly concerned about the environmental impact of cigarette waste. I imagine that many of us were shocked to learn that cigarette butts are the main source of beach litter in our state, and that each discarded cigarette may take as much as 18 months to disintegrate.

Of course, from the point of view of the American Heart Association, the main importance of this measure is the tremendous potential to improve our city's public health. The science is irrefutable. Study after independent study shows that tobacco kills. As little as 30 minutes of exposure to tobacco smoke, whether inhaled through a filter or involuntarily inhaled through secondhand smoke, leads to a hardening of the arteries within our cardiovascular system. Exposure to smoking can also increase the risk of clotting in our bodies, which may lead to a heart attack or stroke.[i] As long as tobacco remains the leading cause of preventable death in our city, and cardiovascular diseases are the number one source of overall death, the American Heart Association will strongly support thoughtful policies that encourage smokers to stop this deadly habit.

Additionally, the 2009 analysis that found nearly 60% of non-smoking New Yorkers possess an elevated level of cotinine in their blood is alarming. Cotinine is a by-product of tobacco use. It cannot be found in any other environmental factor, except for tobacco smoke. So this study shows that millions of New Yorkers are being subjected to secondhand smoke, despite the city's best efforts to restrict smoking in public locations.[ii] By placing additional restrictions at our city's parks, beaches and pedestrian plazas, the city will serve to better protect the more than 80% of our population who do not smoke.

You may have heard from a few representatives of the tobacco industry who want you to believe that this policy will infringe upon people's right to smoke. In fact, this measure does not. People can still smoke at home, on sidewalks, in their cars, and on other private property – though for the sake of their health and the health of their own family members, we hope that they do not. What this measure does do is to protect the rights of the vast majority of New Yorkers, who are non-smokers, to enjoy the beautiful public parks and beaches of New York City without unwillingly inhaling poisonous chemical smoke and without unintentionally subjecting their children to learning the harmful habit of smoking.

The American Heart Association would also like to emphasize our intention to support the strongest policy possible that addresses this issue. The intention behind this proposal is to protect our city's environment, increase public safety and inspire a healthier population. While the proposal to limit smoking to designated areas is well-intentioned, our concern is that the goals of the policy would be undermined. Sectioning off where a smoker may or may not light their cigarette has never worked in effective tobacco control policies. We discourage the Council from considering this option regarding our outdoor public areas.

Therefore, given the public health benefits of more New Yorkers quitting smoking and us removing the influence of smokers from our young people, the American Heart Association strongly encourages the passage of Intro 332 and we look forward to its successful implementation.

---

[i] http://www.americanheart.org/presenter.jhtml?identifier=4545

[ii] Jennifer A. Ellis, et al., Secondhand smoke exposure among nonsmokers nationally and in New York City *Nicotine Tob Res (2009) 11(4): 362-370 first published online January 1, 2009 doi:10.1093/ntr/ntp021*

Testimony in Support of Intro 332
Submitted by Brynne Thompson
59 John St, New York, NY
brynneanddave@mac.com

October 14, 2010

Testimony submitted to the Council Committees on Health and Parks and Recreation

Dear Members of the Committee:

I am writing in support of the proposed ban of cigarette smoking in New York City's parks, beaches and pedestrian plazas.

I find second hand smoke particularly troubling, as citizens who choose to make responsible and healthy decisions for their lives are negatively impacted by the irresponsible choices of others.

Our city's parks, beaches and plazas are intended to be public goods, in service to all citizens, providing places of rest and vibrancy, reflection and play, places of restoration and places of health. Enabling smokers to pollute these areas damages the public good for all.

Every day I walk through city parks. I did so when I was pregnant and I do so now with my nine week old son. Every day I find myself aiming to avoid, move around, or skirt away from smokers. We choose to keep our home as clean an environment as possible. It's discouraging that a walk outside to give my son fresh air results in a perhaps much more negative effect of his tiny lungs as he breathes in secondhand smoke.

The costs of continuing to allow smoking in our public lands is too high, not only for me and my family personally, but for all citizens. Why implicitly support a habit that has only negative effects on the health not only of the smoking members of our community but the responsible non-smokers as well?

Please renew the intended purpose of the parks, beaches and public lands as a public good for ALL in New York City; that aims to offer health and vibrancy. Clean air is critical to fulfilling this purpose.

Vote yes on Intro 332!

Sincerely,

Brynne Thompson

Testimony of Dr. Maureen Killackey, Chief Medical Officer
American Cancer Society of New York and New Jersey

New York City Council Committees on Health and Parks
Public Hearing on Intro 332, October 14, 2010

Chairpersons Brewer and Mark-Viverito, members of the Health and Parks committees, thank you for the opportunity to speak about Intro 332, prohibiting smoking in parks, beaches and pedestrian plazas. My name is Maureen Killackey, I am the Chief Medical Officer for the American Cancer Society of New York and New Jersey. I am also the Medical Director of the Cancer Program at Memorial Sloan Kettering Cancer Center, and have been a cancer physician for nearly 30 years.

The American Cancer Society is committed to reducing the devastating burden of cancer in our communities. Tobacco use and exposure to secondhand smoke (SHS) account for nearly one in three cancer deaths—deaths that are completely preventable. Annually, tobacco kills 25,000 New Yorkers. We are very pleased to say that New York has been a leader in saving more of those lives than ever before.

Support for Smoke Free Outdoor Recreational Spaces
Your work has helped reduce tobacco use in the city to historic lows, and clearly established New York City as the leader in tobacco control. Enacting legislation to prohibit smoking *entirely* in parks and other public recreation areas makes good public health and environmental sense, and would maintain our leadership. Many other jurisdictions have already surpassed us on this issue.

According to the American Nonsmokers' Rights Foundation, across the country, more than 700 state and local governments have passed laws restricting outdoor smoking at playgrounds, building entrances and other public areas, 200 municipalities in New York State alone. Comparable cities are already on this path; Chicago, Los Angeles, Santa Monica, and Seattle have all passed legislation to make their parks and beaches smoke-free.

The American Cancer Society believes no one should be subjected to second hand smoke. We are proud to work with you in achieving this mission.

We do not support the proposal to partially prohibit smoking, or allow smoking only in certain areas of our public spaces. We know from our vast experience that these weaker proposals do not work, and will not adequately protect people from the harms of second hand smoke. Our testimony today will focus on support for Intro 332.

As a long time New Yorker, and an avid runner and biker in this city, I'm personally looking forward to passage of Intro 332. For years, I have had to run through clouds of tobacco smoke from the many smokers congregating near my running path. This is dangerous to my health, and a deterrent to using our public recreational areas for exercise. *(Exercise, which can reduce my risk of death from cancer.)* I'm not alone in this. There is public support for this measure. A 2009 NYC Zogby poll shows 65% of New Yorkers are in favor laws banning smoking at outdoor recreational places, including parks, ball fields and playgrounds.

Harms from Second Hand Smoke

Cancer is rapidly becoming a global pandemic. World Health Organization statistics show that this year, cancer will become the number one cause of death in the world – with much of the rise in cancer deaths attributed to widespread tobacco use and exposure to secondhand smoke.

Every year, 3,400 nonsmoking adults in the U.S. die of lung cancer as a result of breathing secondhand smoke. So we will echo the Surgeon General; there is no safe level of exposure to secondhand smoke. Not inside. Not outside. Not anywhere.

Second hand smoke (SHS) contains more than 4,000 substances, more than 50 of which are known or suspected to cause cancer in humans and animals, and many of which are strong irritants[1]. It is estimated that more than 126 million nonsmoking Americans are exposed to SHS in homes, vehicles, workplaces, and public places. Some studies have even reported an association between SHS exposure and breast cancer.

Many people think that encountering second hand smoke outdoors is not a worry. This is not the case. A recent study from Stanford University showed that even brief exposure to secondhand smoke *outdoors* can be

[1] California Environmental Protection Agency. *Health Effects of Exposure to Environmental Tobacco Smoke: Final Report.* Sacramento, CA:California Environmental Protection Agency, Office of Environmental Health Hazard Assessment; 1997.

harmful.[2] Furthermore, inhalation of toxic secondhand smoke is damaging to the body over time. Repeated exposure to secondhand smoke, a Class A carcinogen, has a cumulative negative effect on a person's health.

And we know that the majority of New York City's non-smokers are being exposed to second hand smoke. A study by the NYC Department of Health and Mental Hygiene found that found that 57% of us have elevated levels of cotinine (a by-product of second-hand smoke) in our blood.

Laws that prohibit smoking in public places and create smokefree environments are the most effective approach to prevent exposure to – and harm from – SHS. An additional benefit of smoke-free policies is the modification of smoking behaviors among current smokers. Momentum to regulate public smoking began to increase in 1990, and these laws have become increasingly common and comprehensive[3].

Protect Our Children

We all want to keep our children safe, that's why NYC playgrounds already ban smoking. But our children deserve to be safe from the harms of secondhand smoke in all of the public parks and beaches we bring them to. According to the Environmental Protection Agency, children breathe in 50% more air pollution per pound of body weight than adults[4]. As a result they are more susceptible to the dangers associated with tobacco smoke even when outdoors.

In addition to providing protection against harmful exposure to secondhand smoke, there is strong evidence that smoke free policies decrease the prevalence of both adult and youth smoking[5]. So, Intro 332 may have a powerful effect on our youth smoking rates. Children and teens are easily influenced by adult smoking that they observe in public. Reducing the frequency with which children see adults smoking will have an impact on the risk of young people starting to smoke. Each day 5,000 kids under the

---

[2] Neil E. Klepeis, Wayne R. Ott, and Paul Switzer, Stanford University, Stanford, CA
Published in the May 2007 edition of the Journal of the Air & Waste Management Association

[3] National Cancer Institute. *State and Local Legislative Action to Reduce Tobacco Use. Smoking and Tobacco Control Monograph No. 11.* Bethesda, Maryland: US Department of Health and Human Services, National Institutes of Health, National Cancer Institute NIH Pub. No.00-4804; 2000.

[4] http://www.epa.gov/otaq/retrofit/documents/f03021.pdf

[5] International Agency for Research on Cancer. *IARC Handbooks of Cancer Prevention. Volume 13: Evaluating the Effectiveness of Smoke-free Policies.* Lyon, France: IARC Press; 2009.

age of 18 try their first cigarette. We are always working to reverse this dangerous trend.

Additionally, cigarette litter can be harmful to children playing in parks and beaches, and it is certainly harmful to the environment. Cigarette butt litter can take as long as a year and a half to decompose. They are the most common form of litter on the planet; the majority of litter in our parks and beaches, and they put our children, pets and wildlife at risk.

Conclusion

Laws that create smoke-free public areas are the most effective approach to reduce the harms of secondhand smoke. We are committed to helping Intro 332 become law, and will continue to work with you to educate the public on the deadly toll of tobacco use.

New Yorkers deserve the chance to take their children to the playground or spend an afternoon walking along the beach without being exposed to the dangerous effects of tobacco smoke. This legislation is the natural next step, building upon successful smoke-free policy in NYC that will protect our families from the harmful effects of second-hand tobacco smoke. Once again, thank you for standing up for the health and safety of New Yorkers.

NYC Health

Testimony

of

Dr. Thomas A. Farley

Commissioner
New York City Department of Health and Mental Hygiene

Before the

Committee on Health and Committee on Parks and Recreation

Regarding

Intro 332: Prohibiting Smoking in Pedestrian Plazas and Public Parks
Intro 381: Prohibiting Smoking in Pedestrian Plazas and Public Parks Except for Smoking Areas Within Public Parks

October 14, 2010

250 Broadway
New York, NY

Good afternoon, Chairperson Arroyo, Chairperson Mark-Viverito and members of the New York City Council Committees on Health and Parks and Recreation. I am Dr. Thomas Farley, Commissioner of the New York City Department of Health and Mental Hygiene. I would like to thank you for the opportunity to comment on Intro 332 and Intro xxx. I strongly support Intro 332. Working together, the Bloomberg Administration and the City Council have made historic progress to reduce smoking and protect all New Yorkers from the harmful effects of tobacco smoke. This law would build on our success and make our parks and beaches safer, cleaner places to play and exercise.

Beginning in 2002, the Administration launched a comprehensive tobacco control program to reduce and prevent smoking. By executing in quick succession multiple, intensive, synergistic program components – taxation, legislation, public education, and the promotion of smoking cessation — and rigorously evaluating these efforts, the City has made enormous progress. New York City's current smoking rate of 15.8% is the lowest on record, with fewer than one million adult smokers in the City. This represents 340,000 fewer smokers than in 2002. We are equally proud of the dramatic decrease in smoking rates among public high school students -- a 64% decline between 1997 and 2009. At 8.4%, New York City's current rate of youth smoking is among the lowest in the country.

But we still have work to do. Smoking is still the leading cause of preventable death in New York City, responsible for 1 in 3 preventable deaths and 1 in 7 deaths overall. In 2009, there were more than 7,500 deaths attributable to smoking among New York City residents age 35 and older, representing 14% of all deaths in the City. Of New York City's current smokers, one-third are expected to die from a smoking-related illness.

More than 950,000 adults and 18,000 public high school students still smoke in New York City. Moreover, the decline in our smoking rates has leveled off in recent years. And even though a smaller percentage of New Yorkers smoke than the national average, a greater percentage of us are exposed to the harmful effects of secondhand smoke.

In this context, creating smoke-free parks and beaches makes sense for several reasons. First and foremost, it would reduce the number of people exposed to the harmful health effects of secondhand smoke. Secondhand smoke is deadly and causes premature death and disease in children and adults. It contains more than 250 toxic or carcinogenic chemicals, including carbon monoxide, hydrogen cyanide, benzene, and arsenic. As stated by the US Surgeon General, "*there is no risk-free level of exposure to secondhand smoke*". Despite New York City's low smoking rate and our ban on smoking in virtually all workplaces, a large number of City residents have elevated levels of cotinine in their blood, a by-product of nicotine indicating recent exposure to tobacco smoke. In fact, while 45% of nonsmokers in the rest of the nation have elevated cotinine, the rate in New York City is 57%.

There are many harmful health effects of secondhand smoke. Young children are especially vulnerable because their bodies are still developing. Secondhand smoke exposure can increase respiratory infections, cause ear problems, and worsen asthma. Adults exposed to even low levels of smoke can have abnormalities in gene functioning similar to those seen in regular smokers, and are more likely to have reduced lung function and respiratory symptoms.

Exposure to secondhand smoke also has acute adverse effects on the cardiovascular system. Secondhand smoke causes an estimated 46,000 deaths from heart disease in the U.S. each year. Thirty minutes of exposure to second-hand smoke can increase risk of blood clots, slow the rate of blood flow through the arteries in the heart, injure blood vessels, and interfere

with their repair. In healthy adolescents, even modest exposure to tobacco smoke may be harmful to blood vessels.

Despite the widespread perception that secondhand smoke simply dissipates in the open air, this is simply not true. Studies have shown that secondhand smoke exposure can be just as high outdoors as inside. For example, studies conducted in Canada and Australia at outdoor restaurants have demonstrated that air around smokers contains significant levels of fine particle pollution from secondhand smoke, and that these levels increase when the number of smokers increase. Nonsmokers eating at outdoor bars and restaurants where smoking is allowed have high levels of cotinine in their blood, indicating exposure to secondhand smoke. And a person sitting within three feet of a smoker outside can be exposed to levels of secondhand smoke similar to those found indoors.

Last week, our environmental health staff conducted a few measurements of airborne particles generated by smokers in New York City parks to illustrate this. They found that levels of fine particles measured three feet from a single cigarette smoker were more than 8 times higher than background levels. Even at a distance of about six feet from the smoker, average particle levels were three times higher than background levels and more than double that of levels recorded at the entrance to the Holland Tunnel.*

Smoking in parks and beaches not only directly harms people trying to enjoy these recreational facilities; it also contributes indirectly to smoking initiation by children. Adults serve as role models for children, both positively and negatively, and when children see

*Average levels measured over 2 minutes during active smoking. Actual values were 163 ug/m3 and 59 um/m3 from distances of 3 and 6 feet, respectively. Background levels in park were 19 ug/m3. Background levels near Holland tunnel were 22 ug/m3.

adults smoking they are more likely to view smoking as an acceptable or even appealing behavior. To put this more simply, children learn to smoke by watching adults smoke. For example, a 2009 study in the journal *Pediatrics* found adolescents whose parents smoke are nearly three times as likely to start smoking as adolescents whose parents do not smoke. It is extremely important that we prevent our children from initiating smoking, because 90 percent of smokers start before they turn 20. If we can protect our children, we can raise an entire generation of New Yorkers free of the damage caused by this addiction.

Smoking in parks in New York is more common than you might think. Ninety percent of respondents in New York City from a state survey reported noticing people smoking in outdoor public areas such as beaches and parks in the last 12 months.

Smoking in parks and beaches has also created a litter problem that harms the beauty of our parks, is costly to clean and is a hazard to children, pets and the environment. A recent survey of parks, playgrounds and beaches in New York City conducted by the Department of Parks with the assistance of the Health Department found that cigarette butts and related litter accounted for 49% of all litter. Cigarette-related litter accounted for an astounding 75% of all litter on beaches, and 33% of all litter in parks. Cigarette butts, made of plastic cellulose acetate, may take more than 18 months to decompose. Anyone who has ever been a parent of a toddler knows that they tend to pick up cigarette butts they find on the ground and put them in their mouths. In 2007, poison control centers around the U.S. received nearly 5,000 calls concerning children under the age of 6 who had swallowed cigarette butts. Cigarettes are also a fire hazard, accounting for 9% of outdoor fires in the U.S.

While New York City has been a trailblazer in many areas of tobacco control, we are behind other areas when it comes to parks and beaches. More than 450 municipalities, including

Los Angeles, Oakland, San Francisco, Salt Lake City and nine jurisdictions in New York State, have prohibited smoking at all or specifically-named city parks. More than 90 municipalities, including Los Angeles, San Diego, Chicago and two jurisdictions in New York State, have prohibited smoking on all or specifically-named city beaches. For example, virtually all of the 80 miles of Los Angeles County coastline are covered by policies that make it illegal to smoke on public beaches, as are over 5,000 acres of public parks and beaches in Chicago.

Making parks and beaches smoke-free is consistent with other park rules that prohibit littering, disorderly behavior, possessing or drinking alcohol, and using glass bottles on beaches and playgrounds. Smoke-free parks and beaches will make these spaces healthier and more enjoyable for everyone.

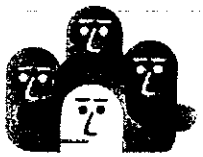
I want to say a word about Intro 381. I appreciate Council Member Vallone's intentions, but this bill would not do enough to reduce the harmful effects of secondhand smoke. Creating smoking areas in parks and beaches would lead to confusion and undermine the reasons for making them smoke-free. Parks should be places where all New Yorkers can enjoy clean air and healthy activities. Families should be able to bring their children to parks and beaches knowing that they won't see others smoking. And smoking areas would not eliminate the cigarette litter in our parks and beaches. It's much easier to explain the law and for people to understand the rules if they cover entire parks and beaches.

Public support for smoke-free parks and beaches is strong. A 2009 Zogby survey found that 65% of New York City adults favor banning smoking at outdoor recreational places such as parks, ball fields and playgrounds. I expect that an overwhelming majority of New Yorkers will support smoke-free parks and beaches here, including people who are now opposed. When the Administration first proposed smoke-free bars and restaurants, only about half of New Yorkers

favored the measure. Now, more than 75% of New Yorkers support the law and most people couldn't imagine having to inhale smoke while having a beer or a burger at their neighborhood bar, just as no one could imagine sitting next to a smoker on an airplane. If this bill passes, someday soon New Yorkers will not be able to imagine a time when they had to contend with tobacco smoke and cigarette butts in their parks and beaches.

Frederic Law Olmsted hailed public parks as the "lungs of the City" - sanctuaries where citizens could go to escape overcrowded conditions and polluted air. We need to ensure that all of our parks and beaches provide just that -- a healthy environment in which to relax and enjoy the surroundings. With passage of Intro 332, we will protect New York City residents and visitors from the harmful health effects of secondhand smoke, reduce smoking among children and protect our environment from cigarette litter. Because of pioneering efforts by New York City, smoke-free standards across America and the world have changed. However, given the magnitude of the health problems caused by smoking, we cannot rest on our past success. Making parks and beaches smoke-free is crucial to this effort. I want to thank the Council for considering this legislation and for continuing to work with us to protect the health of New Yorkers. I am happy to answer your questions.

For the Record



REPACE ASSOCIATES, INC
Secondhand Smoke Consultants

101 Felicia Lane
Bowie, MD 20720 U.S.A.

Phone: 1.301.262.9131
Fax: 1.301.262.3865
email: repace@comcast.net
website: **www.repace.com**

Testimony of James L. Repace, Re: Proposed Bills Int. No. 332 (Councilmembers Brewer, et al.), and Int. No. ### (Councilmember Vallone), New York City Council Health & Parks Committee Hearing, Thursday, Oct. 14, 2010.

Chairman Brewer, and Members of the New York City Council, thank you for the invitation to comment on the Council's proposed bills to ban or restrict smoking in public parks and pedestrian plazas. I am a visiting Assistant Clinical Professor at the Tufts University School of Medicine, Department of Public Health and Community Medicine, and a secondhand smoke consultant. I have authored 79 papers on secondhand smoke hazard, exposure, dose, risk, and control. My CV is downloadable from my website.

I support the adoption of Bill No. 332. I have testified before this Council on several previous occasions concerning New York City's landmark legislation banning smoking in workplaces, on the last occasion in support of Mayor Bloomberg's testimony. I have served as an expert witness in numerous legal cases in New York State and elsewhere in state and federal courts, involving injury to plaintiffs from secondhand smoke. Attached is a paper I authored concerning outdoor smoking. Tobacco smoke outdoors is a major nuisance and should be eliminated in places where the public recreates.

The Committees will be considering 2 separate bills. Both would extend the smoking ban to pedestrian plazas and park property. Both bills exempt parking lots, sidewalks next to parks and certain park strips or malls that are in the middle of the road. However Int ### differs from Int 332 (the bill at the link on the committee's website) because Int ### would require the creation of designated smoking areas in park property larger than two acres; the designated smoking area would have to be at least 20% of the total acreage of the park property. I oppose Bill Int ###, which, while an improvement over the present unregulated condition, nevertheless unnecessarily encourages smoking, which is not good public health policy.

Sincerely,

James L. Repace, MSc.

For the Record

From: Evans, Monica [mailto:mevans@grey.com]
Sent: Friday, October 08, 2010 9:56 AM
To: Mancino, Joseph
Subject: Against Smoking Ban in Parks

Hello
Just wanted to let you know that I am against the smoking ban in parks, beaches etc. There's a lot more issues that need to be addressed which I won't go into now. Thanks.

GREYgroup | Famously effective since 1917
Monica Evans, Executive Assistant, Corporate Communications
200 Fifth Avenue
New York, NY 10010
t. 212-546-2207 | f. 212-546-1538
http://www.grey.com

For the Record

From: gr8couple@aol.com [mailto:gr8couple@aol.com]
Sent: Tuesday, October 05, 2010 10:00 AM
To: smdad@optonline.net; Mancino, Joseph
Subject: Thoughts & views on Intro. 332.

Dear Councilman Mancino,

As a cigar smoking citizen born and bred in NYC 62 years ago, and having a 61 year old cigar smoking wife (whose picture has been on the front cover of a cigar smoking magazine) and also born and bred in NYC, we wholly agree, and echo Leonard Waller's views on pending NYC legislation on smoking in public or private outdoor areas.

Consider us, (native New Yorker's) as **another two opposing any additional bans or restrictions** on **a tradition started by the true Native Americans, American Indians.**

The picture below is something we **CAN'T** do anymore in NYC. So instead of spending money and generating tax revenue in NYC we stay home or sit on our back deck in Brooklyn and smoke our cigars.

Sincerely,
Alan and Ann Glasser
2133 66th Street
Brooklyn, NY 11204
greatguy49@aol.com

For the Record

From: john(brightnrss3@verizon.net) [mailto:brightness3@verizon.net]
Sent: Wednesday, October 06, 2010 4:43 AM
To: JMancino@council.nyc.gov.
Subject: PROTECT NEW YORKERS FROM SECONDHAND SMOKE IN PUBLIC PARKS AND BEACHES

Dear Sir,

I fully support
the bill to PROTECT NEW YORKERS FROM SECONDHAND SMOKE IN PUBLIC PARKS AND BEACHES.

I hope the bill will be passed

Dr John Wong
brightness333@yahoo.com

For the Record

October 13, 2010

The New York City Council
250 Broadway
Committee Room, 14th Fl.
New York, NY 10007

To Whom It May Concern:

On behalf of the Board of Bronx Council for Environmental Quality (BCEQ), I am submitting testimony in support of Intro 0332-2010: a local law to amend the administrative code of the city of New York, in relation to prohibiting smoking in pedestrian plazas and public parks. BCEQ is a nonprofit organization that seeks to establish – as an inherent human right – a sound, forward-looking environmental policy regarding an aesthetic, unpolluted, environment protecting a natural and historic heritage.

It is in this vein that we believe and support the notion that making our pedestrian plazas and public parks smoke-free, it speaks to this focus. We are not only concerned about the health issues from second-hand smoke but also the amount of litter from cigarette butts in our parks. Cigarette butts are toxic, slow to decompose, costly to manage and growing in volume. However, we would like to note that we are concerned about how this local law will be enforced due to the limited number of New York City Parks Enforcement Patrol officers.

The Bronx Council for Environmental Quality fully support Intro 0332-2010 which will be the first step in making our public green spaces smoke-free.

Thank you for your consideration.

Very truly yours,

Joyce Hogi
President ~ BCEQ

For the Record

124 GALE PLACE #GRA
BRONX, NY 10463
Tel: 718-601-1460
Fax: 718-601-1574

WEBSITE:
www.vancortlandt.org
EMAIL:
info@vancortlandt.org

The New York City Council
250 Broadway
Committee Room, 14th Fl.
New York, NY 10007

To Whom It May Concern:

On behalf of the Board and the staff of The Friends of Van Cortlandt Park, I am writing today in support of Intro 0332-2010: a local law to amend the administrative code of the city of New York, in relation to prohibiting smoking in pedestrian plazas and public parks. The Friends of Van Cortlandt Park is a nonprofit organization dedicated to the conservation and improvement of Van Cortlandt Park through educational and stewardship programs.

We believe that by making our pedestrian plazas and public parks smoke-free, it will improve the experience of those who use all of our public green spaces. Van Cortlandt Park hosts over 2.5 million visitors each year and this local law will help keep their experience joyful. We are not only concerned about the health issues from second-hand smoke but also the amount of litter from cigarette butts in our parks. Cigarette butts are toxic, slow to decompose, costly to manage and growing in volume. However, we would like to note that we are concerned about how this local law will be enforced due to the limited number of New York City Parks Enforcement Patrol officers.

The Friends of Van Cortlandt Park fully support Intro 0332-2010 which will be the first step in making our public green spaces smoke-free.

Sincerely,

Christina A. Taylor

Christina A. Taylor
Executive Director

For the Record

From: Elli Ventouras [mailto:events10@yahoo.com]
Sent: Tuesday, October 05, 2010 9:55 AM
To: Mancino, Joseph
Subject: smoking bans in parks and beaches

I think that this is going too far. This is now turning into segregation, which is illegal. These place are to be used by the public and smokers are part of the public. If a non smoker does not want to smell the smoke they can go to another part of the park. I understand not having smoking in playgrounds where kids are there but this is becoming ridiculous.

Elli Ventouras

For the Record

From: patriziav@aol.com [mailto:patriziav@aol.com]
Sent: Tuesday, October 12, 2010 9:28 PM
To: Siman, Adira
Subject: Re: smoke free testimony

Date 10/14/10

Good afternoon. I am sorry that I am not able to be there in person to testify in support of this important legislation. My name is Patrizia Vartanian and I am a Staten Island resident and mother of a young child.

I suffer from asthma and allergies to tobacco smoke – cigarettes, cigars, and pipes. Whenever I am around secondhand smoke I have difficulty breathing, my eyes water and itch. It is annoying and uncomfortable and not the experience I want to have when I go to South Beach for a potluck picnic or when I'm getting my exercise by walking the loop at Silver Lake.

I am also greatly concerned for the health and welfare of my child who is also prone to allergies. When she is playing at the beach or park, I don't want her to have to breathe in nasty cigarette smoke.

Cigarette butts are also disgusting forms of litter that are everywhere, but especially at our beaches and parks. I can't tell you the number of times that my daughter has used cigarette butts to decorate a sand castle! To her, they are as common as seashells.

I am happy that the playgrounds are already smoke-free. I often point it out to other parents who may be smoking and not aware of the park rule. They are often embarrassed and quickly put out their cigarettes. I think it would be terrific for our health and our environment if the rest of the parks and beach areas were also smoke free.

Thank you.

Patrizia Vartanian
Brewster Street, SI NY 10304

For the Record

Testimony of Kevin O'Flaherty

Director of Advocacy – Northeast Region

Campaign for Tobacco-Free Kids

Before The New York City Council

Committee on Health and Parks

Thursday October 14, 2010

Thank you for the opportunity to express our support for the proposal to make all parks and beaches in New York City completely smoke-free. New York City has been a global leader in the fight against tobacco use and has made significant progress by implementing higher tobacco taxes, comprehensive smoke-free air laws and hard-hitting tobacco prevention and cessation campaigns. The proposed law completely prohibiting smoking in parks and at beaches continues the city's innovative efforts to reduce tobacco use and exposure to secondhand smoke. The policy would not only protect everyone's right to breathe clean air, it would also have additional benefits for the environment and our treasured public spaces.

Cigarette Litter Costs the Environment and the City

In addition to being a nuisance, cigarette butts are toxic, slow to decompose, and costly to remove from our parks, beaches and other public spaces. Of course, many smokers dispose of their cigarette-related litter properly, but it is evident from just walking along a New York City beach or through a park that others do not, resulting in litter from cigarette butts and other tobacco related packaging.

The Ocean Conservancy's annual worldwide litter audit shows just how pervasive cigarette litter is in the United States and around the world. Their most recent report found that, of the individual items tracked, cigarettes and cigarette filters were the most prevalent items found during the cleanup, accounting for 28% of all the litter collected from beaches and coastal areas. In fact, cigarettes and cigarette filters accounted for *more than twice* the number of any of the other 43 debris items tracked.[1]

In a 2009 article, researchers called cigarette butts "an environmental blight," noting that cigarette filters pose a serious litter and toxic waste disposal problem because the cellulose acetate in the filters is photodegradable but not bio-degradable. This means that the sun will eventually break the filter into smaller pieces, but the source material never disappears; it essentially becomes diluted in water or soil. The study also noted that discarded cigarette butts are not only unsightly; they are also toxic in and of themselves.[2] In another recent study, researchers at San Diego State University evaluated the effects left-over cigarette butts have on marine life and found that the chemicals from just one filtered cigarette butt had the ability to kill fish living in a one-liter bucket of water.[3]

Smoking in parks also poses a danger of fire, further endangering the environment. In 2007, a discarded cigarette ignited a massive fire in Los Angeles' Griffith Park, burning one quarter of the park's natural habitat.[4]

Cigarette litter is also costly to remove from our parks, beaches and other public spaces. A 2009 litter audit in the city of San Francisco found that cigarette butts and other small tobacco litter (matches, filters, etc) accounted for nearly 25% of all litter observed, with the clean up costing the city more than $6 million dollars in direct costs alone.[5]

A smoke-free policy for our parks and beaches would help promote a safer environment for the families of New York City, while helping reduce the costs associated with cleaning up cigarette butts and other tobacco-related litter.

Benefits to Public Health

A smoke-free policy for our parks and beaches would also work to protect public health and safety. We all know that exposure to secondhand smoke is a serious health hazard, causing cancer, heart disease and serious respiratory disease in non-smokers.[6] Secondhand smoke contains more than 4,000 chemicals, including more than 60 found to cause cancer.[7] Secondhand smoke is especially hazardous for vulnerable populations such as children, the elderly and people with certain health conditions such as asthma.

We are continuing to learn more about the health impact of secondhand smoke in outdoor areas. While the science continues to evolve, it is clear that we are impacted by tobacco smoke, even outdoors. Just ask anyone who has moved their blanket on a city beach or moved from a park bench because someone started smoking nearby.

A study analyzing tobacco smoke in outdoor areas found that air pollution from outdoor tobacco smoke can be quite high near active smokers.[8] The Stanford University researchers found that there is a health basis for banning smoking in outdoor areas. They noted that concentrated streams of outdoor tobacco smoke can, at the very least, act as a respiratory or eye irritant. But they also stated that outdoor tobacco smoke may also pose a serious health hazard for severe asthmatics even if the exposure is transient, since tobacco smoke may act as a trigger.

In addition to any harm caused by the smoke itself, discarded cigarette butts contain the tars and chemicals absorbed by the filter, posing a health hazard to small children who routinely tend to pick up items off the ground and place them in their mouths.[9] In 2008, the American Poison Control Centers received over 5,000 reports of children under age 6 ingesting cigarettes.[10]

And of course, having smoke-free public spaces sets a healthy example for the city's children. Allowing tobacco use in family-friendly places such as parks and beaches sends a message to our children that smoking is acceptable, when in fact we should be sending the opposite message, and doing everything we can to prevent them from becoming smokers.

Smoke-Free Policies Across the Country

You can find smoke-free beaches and smoke-free parks in communities across the country, to the delight of residents and tourists alike. According to the American Nonsmokers' Rights Foundation, 100 municipalities across the country have smoke-free beaches and close to 500 have smoke-free parks.[11] And dozens of counties in New York State have adopted smoke-free policies for their parks or beaches.[12]

Conclusion

In closing, we support the proposal to make all parks and beaches in New York City completely smoke-free. Everyone should have the right to breathe clean air in our city's outdoor recreational areas. We urge the Council to take decisive action, and reject attempts for weaker legislation, including establishing smoking areas within the parks. As we've learned after many years of evolving policies to protect people from secondhand smoke – partial solutions just do not work. Smoking sections did not work in airplanes, workplaces, restaurants or bars. We have no reason to believe they would work in New York City parks. And smoking areas, particularly large areas covering twenty percent of a park, would do nothing to address the extensive environmental damage caused by tobacco product litter.

[1] Ocean Conservancy. 2009. A Rising Tide of Ocean Debris: International Coastal Cleanup 2009 Report. Washington DC: Ocean Conservancy. See http://www.oceanconservancy.org/site/PageServer?pagename=icc_report

[2] Novotny, T.E., K. Lum, E. Smith, V. Wang, and R. Barnes. 2009. Cigarette Butts and the Case for an Environmental Policy on Hazardous Cigarette Waste. International Journal of Research in Public Health 6:1691-1705. See http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2697937/

[3] See http://newscenter.sdsu.edu/sdsu_newscenter/news.aspx?s=71209

[4] http://www.ggpnc.org/prosnl-1-0706.pdf

[5] Health Economics Consulting Group LLC. Costs of Tobacco Litter in San Francisco (2009). See http://www.sfenvironment.org/downloads/library/tobacco_litter_study_hecg_062209.pdf

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

[7] National Cancer Institute. *Risks Associated with Smoking Cigarettes with Low Machine-Measured Yields of Tar and Nicotine.* Smoking and Tobacco Control Monograph No. 13. Bethesda, MD: U.S. Department of Health and Human Services, National Institutes of Health, National Cancer Institute, NIH Pub. No. 02-5074, October 2001. http://dccps.nci.nih.gov/tcrb/monographs/13/m13_5.pdf

[8] Klepeis N.E., Ott W.R., and Switzer P. (2007) "Real-Time Measurement of Outdoor Tobacco Smoke Particles," *Journal of the Air and Waste Management Association*, 57:522-534. See also http://tobaccosmoke.exposurescience.org/outdoor-tobacco-smoke

[9] http://www.tobaccofreenys.org/Tobacco-Free-Outdoors-Campaign.html

[10] 2008 Annual Report of the American Association of Poison Control Centers' National Poison Data System (NPDS): 26th Annual Report. See http://www.aapcc.org/dnn/Portals/0/2008annualreport.pdf

[11] Americans for Nonsmokers' Rights, October 2010. See http://www.no-smoke.org/pdf/SmokefreeBeaches.pdf and http://www.no-smoke.org/pdf/SmokefreeParks.pdf.

[12] Tobacco Free New York State. NYS Tobacco Free Recreation Areas. http://www.tobaccofreenys.org/pdf/Parks-And-Rec-Areas-Tobacco-Policies-NY.pdf

For the Record

Statement of Dr. Daniel Seidman,

Director of Smoking Cessation Services at Columbia University Medical Center

October 14, 2010

Laws that restrict smokers from smoking freely in indoor public spaces have protected the health of nonsmokers and smokers alike. For those trying to quit, exposure to cigarette smoke is a major relapse risk. These laws, therefore, have also provided much needed support for the efforts of those smokers who decide to quit to do so successfully.

It is also a laudable goal of the current legislation to protect the health of nonsmokers and smokers alike from tobacco smoke when they make use of public parks and beaches for recreation and relaxation. While science supports the need to protect people who are in close proximity to smokers in such public outdoor areas, civility further dictates that the burden to move away under such circumstances should not fall just on those who are not smoking.

At the same time, if we are using science to help direct legislation and public health policy, then we should also take this as an opportunity to review progress in the science of clinical research and treatment for smoking addiction. This will further allow us to provide appropriate assistance to smokers who will be subject to new restrictions.

As smoking is restricted in indoor public areas and homes, this has had some unintended consequences on smoking patterns. Some smokers have become "intermittent," or part-time smokers, an emerging, stubborn form of cigarette addiction which, by some estimates, applies to up to 25% of smokers today. Another group that requires additional assistance are the "hard-

core" smokers (those who meet the clinical definition of nicotine dependence) whose rates of smoking have remained constant as the rates of smoking in the general population have dramatically decreased. Great scientific progress has been made in helping smokers with cognitive-behavioral psychotherapy along with FDA approved medications (http://www.huffingtonpost.com/daniel-seidman/defragmenting-healthcare_b_458567.html) and yet these services are not integrated into our local healthcare services due to lack of funding.

Yes protect the public from tobacco smoke in outdoor areas but also protect smokers and their families by applying advances in the science and clinical treatment of tobacco addiction to assist every smoker who wants to quit. The burden of smoking-caused disease falls disproportionately on the poor so those smokers who rely on Medicaid and Medicare for their coverage also need to be offered state-of the art smoking cessation services. Legislation to protect the population from tobacco smoke based on scientific advances must be coupled with treatment services based on scientific advances to assist all smokers and their families. Restrictive health care policies which deny smokers appropriate, scientifically-supported treatments can no longer be tolerated when society uses science to severely restrict smoker's rights to smoke in public.

It is important to remember that the federal government and the state of New York receive substantial revenues from each pack smoked. The economic benefits from taxes on smoking go back to the beginning of the republic, and these very substantial revenues have been collected all along to help build and pay for our American way of life, including our great parks and recreation areas. If we are invoking the science of public health to legislate protection of

nonsmokers from the tobacco smoke of others, then the science of treatment and clinical research must also be carefully considered and given equal weight to help protect the lives of smokers and their families from the devastating economic, emotional, and health effects of smoking-caused disease, disability and death.

It is crucial that the government not rely on legislation alone to change a deeply ingrained behavior such as smoking, but also offer every smoker state of the art help. This needs to include appropriate treatment for those smokers still struggling with their addiction and who are less likely to respond to legislation alone or to public health phonelines.

FOR THE RECORD

Testimony Before The City Council Health Committee Hearing on Intro 322/2010 – Legislation to make NYC Parks, Beaches, and Pedestrian Plazas smoke free

Date 10/14/10

Good afternoon. Thank you for allowing me to submit my written testament as I am not able to attend in person in support of this critical legislation. My name is Weijing Shi, and I am a Chinese-American Planning Council Brooklyn Branch Director.

Smoking is the cause of nearly 85 percent of all cases of lung cancer in the United States, but smoking accounts for other types of cancers as well. My father was a smoker, and he died of lung cancer. I love my father so much. His death makes me extremely sad. The doctor said that his lung cancer was related to his smoking. I believe that if he did not smoke, maybe he will not suffer from lung cancer, and his life will be longer. Therefore, I support any effort to stop smoking.

I am very happy to that City Council is proposing to make NYC's Parks, Beaches and Pedestrian Plazas smoke-free. I want my community, myself and our youth to be having the right to breathe clean/fresh air and be protected from the deadly hazards of second hand smoking!

Thank you.

Weijing Shi
Brooklyn Branch Director
Chinese-American Planning Council, Inc.
4101 8th Avenue, 4th FL., Brooklyn, NY 11232
Tel: (718) 492-0409 Ext: 303
Fax: (718) 567-0397
wshi@cpc-nyc.org

FOR THE RECORD

ASTHMA FREE SCHOOL ZONE

Director: Rebecca Kalin, MA, MPH, CHES

rk@afsz.org
T: 212-533-6615
www.afsz.org

Real World Foundation
131 Avenue B, 1st Floor
New York, NY 10009

October 13, 2010

Distinguished Members of the New York City Council:

The **Asthma Free School Zone** is a school-based program concerned with the respiratory health of children. Since 2001, the AFSZ has worked with nearly 150 New York City elementary schools that serve over 60,000 children. We have trained more than 12,000 teachers and parents on the dangers of airborne pollution and its consequent effect on student achievement. We were the instigators of the 2004-05 Attorney General's one-minute idling agreement with metro-area school bus fleets, the 2007 NYS law that prohibits all school bus idling near schools, and the 2009 NYC one-minute school zone idling law. For over 8 years, we have promoted no-smoking policies in school zones through the posting of durable no-smoking signs.
Today we stand in support of Intro 332, which would make all New York City public parks, beaches and pedestrian plazas smoke-free.

Secondhand smoke is a greater health risk to children than it is to adults. Their special vulnerability stems from their immature immune systems and faster metabolism, which result in greater pound-for-pound intake of food, water and air. Of special significance is the fact that playgrounds, including parks and beaches, are places where children are at their most active and their intake of air is extraordinary. Intro 332 would protect young lungs at work.

Children learn best when they feel well. For children with sensitive airways, air quality can make the difference between being in class or being in a hospital emergency room. The link between environment and health is now as well appreciated as the link between health and school success. Children have many years of future life and thus time to develop diseases that can appear years after early exposure. There is no safe level of second-hand smoke. Intro 332 would reduce the opportunities for disruption of health and achievement in our most vulnerable citizens–children.

By restricting access to tobacco products and reducing exposure to second-hand smoke, Intro 332 will have important benefits for all citizens of New York City. Higher cigarette sales taxes and smoke-free policies have been shown to lower smoking rates, which in turn will reduce negative health impacts in children, including those whose future may end prematurely because of addiction to and death from cigarettes.

Thank you.

Rebecca Kalin

Rebecca Kalin
Founding Director
Asthma Free School Zone

For the Record

Leonard Waller
3021 Briggs Avenue
Apt. # ST-1
Bronx, NY 10458-1633
(347)-297-8501
smdad@optonline.net

Oct. 1, 2010

Joe Mancino
New York City Council
250 Broadway,
New York, NY 10007
Council's Human Services Division

The honorable Mayor Bloomberg, & all members of the New York City Council,
I request the opportunity to express my thoughts & views on Intro. 332, legislation introduced by Council Member Gale Brewer and in conjunction with Mayor Bloomberg, that would prohibit smoking in pedestrian plazas and public parks.I am totally opposed to the ban.

1) "Smokers are not piranhas on society" I am a 60 year old New Yorker, father & grandfather & tax-paying citizen.

1A) The City Parks, Plazas beaches are for everyone, Smokers, Non Smokers, Citizens, & tourists. As to the smell, of "Smoke in the air. The air belongs to everyone & no-one. We smell car exhaust, we smell cooking exhaust from restaurants. We smell the grills burning from Street Vendors. If we go to the parks we smell the smoke from BBQ & picnics. Many of the city's historic & beautiful buildings & Brown Stones have working Fireplaces, that emit smoke.

1B) As to the litter smokers create. We already have laws in place enforcing littering.

1C) As to smoke from tobacco being an offensive odor. I might be sitting next to someone in a park or city plaza & their food has an offensive odor to me. Are we going to ban eating in parks & plazas? What if their cologne or Perfume is overwhelming, do we ban it's use in Parks, beaches, & plazas?

2) Cigar & pipe smokers look to see, smell & feel the product of their desire, & choice. Thus many Cigar shops have either walk in humidors. Or the entire shop is humidified & temperature controlled, & the Cigars & tobaccos are available so choose from.

3) As for the decline of smokers since the Tax increase, the number is not true. Many smokers went to other states, the Internet, & Black Market. Thus the decline in the number of Tax Stamps Sold, & the loss of Tax Revenue to the City, State, & Federal Government.

4) Mayor Bloomberg has stated he doesn't care about the loss of revenue from smokers. It will be made up elsewhere. Most likely in higher taxes for everyone.

5) My objection to the outdoor smoking ban proposal. If I am walking by a park. If I am next to the entrance or the railings, walls, of the park. I might be considered as to smoking in the park. On Central Park West, & South benches go around the outer perimeter of the park. So if I stand next to an outer bench or sit on it. I could be ticketed for smoking in a park. If I am driving an open car through a park or on a park drive is that smoking in the park?

6) I address the issue of increase of Teens smoking cigars. Those inexpensive cigars, "Blunts" El Producto, White Owl or Black & Mild, are cut open & filled with Pot or coke & Pot.. Their cost is usually a dollar or less.

7) Cigar smokers, who purchase quality cigars at licensed Tobacconists & Cigar Stores, spend an average of $5 to $10 a cigar.

7A) These small shops pay rent, buy products, employ people, pay commercial rent tax, collect sales tax, and provide the city with a traditional industry.

8) Raising of the age to purchase Tobacco products to 19. At 18 a citizen can enlist in the Armed Forces. They can make a conscious decision to serve their country. To protect all it's laws & citizens. At any cost. Including the loss of their life.

But the State of New York wants to say they can make a decision to serve their Country. But they can't make a decision as to smoke, or purchase tobacco products.

9) The perception that all smokers are addicted to Nicotine is not true!

Many of us enjoy a Cigar, Pipe, or cigarette, at the end of our day. Some while exercising their pets in the park. It is their personal & quiet time. Some enjoy smoking after a good meal. Although it has become much harder in NYC. since 2003.

I would welcome to opportunity to help in forming any changes to the existing smoking laws. The law must protect us all, smokers, & non-smokers.

Respectfully yours,

Leonard Waller

For the Record

From: "WGueorguiev" <wgueorguiev@gmail.com>
Date: 10/2/2010 9:01:07 AM
To: "speakerquinn@council.nyc.gov" <speakerquinn@council.nyc.gov>
Cc:
Subject: Re: NYC Council

Dear Speaker Quinn,

Hello, this is my testimony to be submitted to the City Council Meeting that will be convening to consider the ban on smoking in public parks and beaches.

Dear City Council,

Hello. According to an August 2010 NY Times article, "The city's health department, in a 2008 study, found that 959,000 adults in New York, or 15.8 percent of that population, smoked."

15.8 is a very significant portion of the population.

This 15.8% of NYC population pay extremely high taxes to smoke. Our taxes support the community. It is unjust and hypocritical to collect our tax dollars and then unjustly propose to remove our right to smoke in tax-supported public parks and beaches. These are the public spaces created for the hard-working, tax payers to enjoy their downtime.

Another recent NY Times article suggested that Gail Brewer idea is to "shame" people into not smoking. Is that your new model of government?
Does this mean since transfats are banned that I could be allowed to approach all overweight people in NYC and demand they put down their fatty food? It is not my business and it is no ones business that I smoke and do not want some ego-driven citizen approaching me. I would deem it as harassment and contact the nearest police officer.

Research has shown that smoking acts neurologically in either a calming or uplifting fashion depending whether it is smoked slowly or quickly. *People use it to manage their feelings*, and for me to relax in this stressful world. It becomes extremely uncomfortable to go somewhere to relax and be unable to because I can't smoke. I will not be able to go to the parks or beaches if this ban goes into effect. SO YOU WILL BE FURTHER LIMITING MY OPTIONS AND FREEDOM AS A CONSUMER AND TAXPAYER!!! I already do not go out as often since I cannot smoke at cafes and bars. I also skip outdoor cafes that do not let me smoke. I instead pick up something and go to a park or my house. So my money does not support many businesses, basically only the ones with an outdoor cafe where I can smoke.

At the beach and park, I spend money at shops, cafes, and vendors. I will stay home and not spend at all if I cannot smoke when I am relaxing.

I, along with everyone I know, smokers and nonsmokers, are against this banas more *impingement on personal freedom*. *The effects of second-hand smoke outdoors are universally agreed to be neglegible*. If we cannot smoke in public, then the removal are the

extremely disproportionate taxes, that were not passed by a democratic vote!, must automatically be removed. Any other scenario is hideously wrong.

*Surely there better things for you to take of in these tough times!!!!!!!!!!!!!!! How about using your brainpower to think of ways to create new jobs for people. * That would represent REAL quality of life.

Wendi Gueorguiev

For the Record

Throggs Neck Community Action Partnership (TNCAP)

Written Testimony in Support of City Council legislation Intro 322-2010 to make public parks and beaches smoke-free

Throggs Neck Community Action partnership (TNCAP) is a community coalition, under the auspices of Archdiocese of New York Drug Abuse Prevention Program. We have been in existence for over 12 years in the Throggs Neck section of the Bronx. We have maintained strong partnership throughout the years with key leaders, local legislators, police, schools and residents.

Throggs Neck is located in the Southeast Bronx which has the highest percentage of smokers in New York City overall. Throggs Neck is on a peninsula, which is surrounded by the East River and the Long Island Sound and has many small beach front clubs throughout the community. TNCAP's goal is to prevent use and reduce alcohol, tobacco and other drug use and the negative effects on children and families. In order to achieve these goals we advocate for healthy and productive life styles for all our residents. TNCAP's mission is to change our environment by implementing environmental strategies that focus on policy change. This has been proven by research to be the most effective strategy for community-wide impact. Subsequently, the smoking data and location of TNCAP has positioned us to support the work of the Bronx Smoke-free Partnership and the proposed Outdoor Air Public Policy.

Did you know?

- Tobacco kills more New Yorkers each year than AIDS, drugs, homicide, and suicide combined? [1]
- There is no safe level of second hand smoke (SHS) exposure. Even brief exposure to SHS can lead to more frequent asthma attacks in asthmatic children. [2]
- Cigarettes are the number one source of beach litter and do not easily biodegrade.[3]
- Cigarette butts have been shows to be toxic, slow to decompose, costly to manage, and growing in volume. [4]
- 10 counties in **New York State** have already adopted smoke-free policies for their beaches. [5]
- 34 counties in **New York State** have adopted smoke-free policies for their parks.[5]

[1] Department of health and Mental Hygiene, "Summary of Vital Statistics 2008."Bureau of Vital Statistics 2008

[2] U.S. Dept. of Health and Human Services "The Health Consequences of Involuntary Exposure to Tobacco Smoke: A Report of the Surgeon General: 6 Major Conclusions of the Surgeon General." Office on Smoking and Health, 2006.

[3] Ocean Conservancy, 2009. Retrieved from http://www.oceanconservancy.org/site/NEWS2?Page=NEWSArticle&id=12551&news_iv_ctrl+0&abbr=icc_

[4] http://www.cigwaste.org/index.php/Research/

[5] Tobacco Free Parks, Beaches, Playgrounds, and Pools in NYC. Retrieved from www.tobaccofreenys.org/.../Parks-And-Rec-Areas-Tobacco-Policies-NY.pdf

FOR THE RECORD

NEW YORKERS FOR PARKS

Testimony Submitted by New Yorkers for Parks for the New York City Council Joint Hearing: Committee on Health and the Committee on Parks and Recreation on Intr. No 0332-210 Prohibiting smoking in pedestrian plazas and public parks

October 14, 2010

New Yorkers for Parks is the independent organization fighting for greener, cleaner and safer parks in all five boroughs. We provide the tools that help communities build better parks for better neighborhoods. Thank you for the opportunity to provide public testimony on this important issue.

General Statement

New Yorkers for Parks supports Intr. No 0332. We believe that this legislation addresses the chronic problem of litter accumulation in New York City's parks and beaches.

Maintenance of Public Spaces

New Yorkers for Parks' *2009 Report Card on Beaches* showed that many beaches score poorly largely due to broken glass and litter on the beach. The Parks Department faces serious challenges in ensuring that the sand remains clean. Cigarette butts are a significant part of the problem. Maintaining the cleanliness of our City's public spaces has been further hampered by this year's severe budget cuts and resulting staff reductions.

Enforcement in Public Spaces

Another challenge that the current budget cuts present for the Parks Department is the lack of funding for proper enforcement of this legislation. The current size of the Parks Enforcement Patrol (PEP) staff is insufficient to enforce a prohibition on smoking in parks. Thus, it is likely that most enforcement of this ban will come from self-policing by other park users.

Recommendation

New Yorkers for Parks supports the prohibition of smoking in parks. While we recognize the challenges of enforcement, we believe that the ban can help to alleviate chronic maintenance issues in parks and beaches.

City of New York
Parks & Recreation

Hearing before the City Council
Committee on Health
Committee on Parks & Recreation

Introduction 332 of 2010
(Prohibiting smoking in pedestrian plazas and public parks)

and

Introduction 381 of 2010
(Prohibiting smoking in pedestrian plazas and public parks except for smoking areas within public parks)

October 14, 2010

Testimony by
Adrian Benepe
Commissioner

I want to thank Commissioner Farley and the Department of Health and Mental Hygiene for their strong advocacy on this issue. We have always enjoyed working with the department on issues ranging from keeping our beaches and pools safe and clean, to childhood obesity, to fitness for adults, and we wholeheartedly support the work you do to make the lives of New Yorkers better and safer. I am honored to partner with you and the Mayor on this important initiative.

In addition, I would like to thank a good friend and fellow West Sider Council Member Gale Brewer, for taking the lead on this initiative on the Council side, and for always being a steadfast friend to parks in her district and across this city.

As the members of the Parks committee hear us say time and time again, the Department of Parks & Recreation is the busy steward of over 29,000 acres of green space across New York City, and our first priority is to ensure that parks, playgrounds, and all of our facilities are safe and clean places for the public to enjoy. Introduction 332 will have a significant positive impact on tens of millions of visitors and New Yorkers who enjoy our beaches and parks year round.

We recently partnered with the Department of Health to evaluate the composition of litter in a selection of New York City parks, playgrounds and beaches. We also analyzed the proportion of cigarette-related litter, including cigarette butts and any cigarette packaging, compared to other litter sources including paper waste, food litter, bottles, cans, broken glass and animal waste. What we found was shocking in that cigarette-related litter accounted for 75 percent of the individual litter items on beaches and 33 percent of litter in parks.

As I had discussed with the Parks committee in June of this year, we began an Anti-Litter initiative to reduce the amount of staff resources spent on cleaning up after a small number of inconsiderate parkgoers. Our jobs could be done in half the time if people simply put their litter in wastebaskets, where it belongs. We believe that this legislation, with the anticipated impact of our efforts to reduce litter, will single-handedly create labor savings that will allow us to more efficiently redistribute our staff resources. That alone, coupled with the improved health and vitality of our parkgoers, makes this legislation a win for everyone.

Our belief is that this legislation will make the City's green spaces even safer and more pleasant for children and adults to play sports, and for visitors of all interests to enjoy healthier and cleaner parks and beaches. We ask the Council to pass Introduction 332. Thank you again for your continued partnership and unwavering support of parks in all five boroughs.

Community Service Society | Fighting Poverty Strengthening New York

Testimony of Priya Mendon
Community Service Society of NY
Before the Committee on Health and the Committee on Parks and Recreation
On Intro 0332-2010 to Prohibit Smoking in Public Parks, Beaches, and Pedestrian Plazas
October 14, 2010

Good afternoon and thank you for the opportunity to speak before you today. My name is Priya Mendon and I am the Director of Community Health Advocates, a program of the Community Service Society of NY. CSS is a 160 year-old institution that has been on the cutting edge of public policy innovations to support poor New Yorkers in their quest to be full participants in the civic life of the nation's largest city. CSS employs a variety of tools – advocacy, direct service, research and policy analysis, and strategic partnerships – to forge consensus on appropriate policy interventions to facilitate the economic mobility of low-income New Yorkers.

CSS commends Speaker Quinn, Councilmember Brewer, and Mayor Bloomberg for their continued commitment to making New York City safer and healthier by introducing legislation to prevent smoking in public spaces that are most frequently visited by families and children. This important bill would prohibit smoking in New York City's public parks, beaches and pedestrian plazas, and will be a well received legislation by New Yorkers who want their families to breathe easier and safely and to reap the benefits of New York's wonderful outdoor spaces.

Tobacco kills. It kills more New Yorkers each year than drugs, AIDS, homicide, and suicide combined. Besides the 7,500 deaths caused by tobacco annually, there are the thousands more New Yorkers who suffer from smoking-related strokes, heart attacks, lung disease, and cancers. Yet you need not be a smoker to be effected by tobacco.

Smoking is the leading cause of preventable death in New York City. Another alarming fact is the negative effects of second hand smoking. For example, even brief exposure to second hand smoking can lead to more frequent asthma attacks in asthmatic children. Hospitalization rates for asthma in East Harlem are five times higher than the rates for the Upper East Side. Besides the tremendous health risks that smoking causes, smoking poses a serious threat to the environment as well. Over 75 percent of the litter found on NYC beaches is cigarette butts; these being the number one source of beach litter. These butts are toxic, slow to decompose and costly to manage for the City.

I want to commend you for your efforts to make New York's parks and beaches smoke-free. There are only positive consequences from passing the bill as it will promote cleaner, safer and environmentally better public spaces. This will allow children and families to feel comfortable and relaxed while spending quality time outdoors. For these reasons, CSS respectfully urges the Council to pass Intro. 0332-2010. Thank you.

READ INTO RECORD

TESTIMONY OF

DARIN JOHNSON, VICE PRESIDENT OF STRATEGIC INITIATIVES AND POLICY AT NEW YORK RESTORATION PROJECT

Before

NEW YORK CITY COUNCIL, HEALTH AND PARKS COMMITTEES

PROPOSED BAN ON SMOKING IN NEW YORK CITY PARKS

THURSDAY, OCTOBER 14, 2010

Good afternoon. My name is Darin Johnson, and I serve as New York Restoration Project's Vice President of Strategic Initiatives and Policy. On behalf of NYRP's Board of Trustees and our Founder Bette Midler, I am here today to share our support for the proposed change in the City's administrative code to prohibit smoking in public parks, beaches, playgrounds, pools, recreation centers and pedestrian plazas.

As the manager and caretaker of Swindler Cove Park along the Harlem River, the New York City Parks Department's non-profit partner in restoring Highbridge Park in Northern Manhattan, and the owner and manager of 55 New York City community gardens, we understand the urgent need to eliminate smoking from our city's open, green spaces.

NYRP has been cleaning and greening New York City parks since 1995, and in that time, we've picked up more than 2,000 tons of garbage – and millions of cigarette butts and hundreds of thousands of discarded cigarette cartons. The littering of cigarette butts is so severe in and around the parks we work in and manage daily that it's often necessary for our operations crews to use leaf blowers to gather the cigarette butts into piles, which are then shoveled into trash bags. Currently, NYRP staff and our team of AmeriCorps members spend more than 20 percent of their work day cleaning trash from our public lawns, gardens, sidewalks and playgrounds. This astounding percentage equates to NYRP spending approximately $200,000 annually to pick up trash, including cigarette-related litter. This is time and money that could be better spent removing invasive plants from our parks, assisting community gardeners, planting trees across our city's five boroughs or teaching students about their responsibility to protect our planet.

A recent audit by the New York City Parks Department found that cigarette butts and related litter accounted for 49 percent of all pieces of litter found in 25 public parks and 25 playgrounds located throughout the city's five boroughs – with cigarette-related litter accounting for 75 percent of the total litter found on public beaches. As the NYC Parks Department faces significant budget reductions

due to the economy, the time spent by Parks employees in cleaning up cigarette-related litter could be better allocated toward park maintenance and public programming.

But it's not just cigarette-litter that plagues our parks and open spaces, it's also the millions of plastic bottles and bags that litter our shorelines, parks and urban forest. And as history has proven, trash-ridden parks often become forgotten, unused places. So, while we believe the proposed ban on smoking in parks and public plazas is a first and important step in reducing litter in New York City, we encourage the City Council to give serious consideration to measures that will significantly reduce or ban the use of plastic bags and bottles in the city, as well as a citywide public education initiative that changes New Yorkers' minds and attitudes regarding litter.

Secondly, as we work to encourage our city's residents and visitors to spend more time in our public parks and playgrounds and on our beaches and waterways, we must ensure these open spaces provide users with clean air breathe. It's for this reason that we also support the ban on smoking in public parks and plazas.

Secondhand tobacco smoke (SHS), also called environmental tobacco smoke (ETS) or passive smoke, is defined as diluted and dispersed air pollutant emissions generated from the consumption of tobacco products. When occurring outdoors, SHS is called outdoor tobacco smoke (OTS). A disconcerting notion is that even smoking outdoors poses a serious health risk for those people who do not smoke and are just exposed to the smoke in the air.

According to studies, a person who encounters secondhand smoke will often have levels of cotitine in their system, which is the hazardous consequence of nicotine. The levels of cotitine in the body can still pose a deadly health risk to people, even those who do not smoke. The New York City Health Department says 57 percent of non-smoking New Yorkers have elevated levels of cotitine in their blood. That means they were likely repeatedly exposed to secondhand smoke in concentrations high enough to leave behind damaging residue in their body. According to a May 2007 Stanford University study, a person sitting within three feet of a smoker outdoors can be exposed to levels of secondhand smoke similar to indoor levels.

The same Stanford University study finds that scenarios where OTS levels might be high include sitting near a smoker on a park bench, on an outdoor patio or standing near a smoker outside of a building. Children who accompany a smoking parent or guardian or are near another smoker may fall victim to such devastating exposure.

The NYC Parks Department, NYRP and other non-profit park conservancies seek to improve the health and quality of life for the families and children we serve by promoting outdoor recreation as a daily necessity and life-long health benefit. The simple and hard fact is that secondhand smoke impedes this important mission and work. If the history of this city has taught us anything it is that the wellbeing of our urban environment and all of our city's residents is directly dependant on the availability of healthy, green spaces where children and adults can play, relax, explore and learn.

Understanding the ill-effects smoking has on the health of our residents and the sustainability of our urban landscapes, NYRP took the lead several years ago in banning smoking in our 55 community gardens. We wanted to ensure our precious community spaces remained not only smoke-free, but also free of the bad habits – both smoking and littering – that continue to plague our city. You should also know that NYRP's no-smoking policy was actually embraced by our community garden members and is respectfully adhered to.

In closing, it's our shared responsibility to ensure that every New Yorker has the opportunity to enjoy a litter- and smoke-free public space – whether it's a park, community garden or beach. By banning smoking in New York City's parks and pedestrian plazas, we will be fulfilling this promise and much more.

Thank you for allowing me to share NYRP's unwavering support for the proposed ban on smoking in public parks and pedestrian plazas today, and we look forward to working with the City Council on its passage.

Contact Information:

Darin E. Johnson
Vice President for Strategic Initiatives and Policy, NYRP
212-333-2552
djohnson@nyrp.org

READ INTO RECORD

TESTIMONY OPPOSING NYC'S SMOKING BAN IN PARKS AND BEACHES
Michael Herklots

I had an interesting day the other day. As the R train pulled into the Steinway Street Station, I was excited to see some available seats on the car. I quickly made my way and sat down with some of my fellow straphangers. Once the doors closed, we all realized that we had made the tragic mistake of getting on the "stinky car"... a term only NY straphangers can relate to. At the other end of the train car was a shopping cart overflowing with bags, and a large winter coat sprawled out, with what I would imagine contained a sleeping person... filling the car with a horrible, sickening stench. It was awful. It instantly made me nauseous and gag. I huddled at the farthest end with the other commuters, exchanging glances and head shakes, and at the next station, we moved immediately to an adjacent car.... JAMMED with folks who had been through the same experience. Some smiled, some gave that classic, "I know how you feel" sympathetic face... but, what are you going to do? It's New York City. We choose to live here.

Finally, I got off the R train at 59th Street and Fifth avenue to walk to our store at 54th and Madison. As I exited the train to the platform, the oh-so familiar stench of ammonia and urine filled my nostrils. It's tough at that station... especially in the morning. I could tell some of my fellow commuters were also not enjoying the smell, as we all covered our noses and mouths and ran up the stairs to cross the street... away from the smell, leaving the beautiful horse drawn carriages behind us. Dodging the puddles and piles, there was fresh air again... and we were all fine. And what are you going to do? It's New York City.

I headed down Fifth Avenue towards 54th Street where our store is located. Walking past the Plaza hotel, I got a nice mouthful of bus exhaust as two busses barreled into the bus stop and accelerated out. Right in my mouth. I coughed, but I moved on...what are you gonna do? It's New York City.

Moving down Fifth Ave, I was overpowered with an explosion of perfume... heavy heavy perfume... like Grandma at Christmas perfume. You could almost taste it, it was so heavy and powerful. "Ah, I must be at 56th street" I thought to myself. You see, Abercrombie and Fitch pumps their fragrance out onto the streets as a sort of marketing/advertising campaign. I crossed the street quickly to the other side of Fifth Avenue and the smell was gone. Hey... It's New York City.

I left the store in the afternoon to make my way to our west side store. As I approached Sixth Avenue, my stomach started rumbling... it was after my normal lunch time, and the smell of all the grilling meats on the food carts half a block away was calling my name! Some people were holding their noses, but it smelled great to me.

I walked up Sixth Avenue towards Central Park, and figured I'd take in a little nature. I found a beautiful bench off one of the paths, sat down and fired up a cigar. There was a nice breeze, and I was just having one of those amazing New York City moments... the juxtaposition of it all... in the middle of a bustling city, to be able to just relax outdoors and enjoy the simple pleasure of a cigar... since there's nowhere else to enjoy a cigar in the afternoon. And in another one of those moments, another New Yorker came by and sat across from me on another bench. He removed a sandwich from his brown paper bag, crumpled the bag and threw it under the bench.

He took the lid off his coffee, took a sip and threw that under the bench too. Some people… littering is illegal in New York.

I continued my stroll through the park, and my eyes started tearing up and I started sneezing. The wind had changed, and I could see stuff in the air… Must be allergies… but then again, I'm in the outdoors in a park surrounded by flowers and trees and grass… it could be anything. A quick blow of the nose, and a wipe of the eyes, and I was fine… it wasn't so bad. It was worth it... for the walk in the park with my fellow New Yorkers. I extinguished my cigar in the ashtray outside Time Warner Center, and went to work.

You know, this city is filled with little things that some people like and others don't. Some smells are pleasant to one and offensive to another. Some people are pleasant and others offensive. Personally, I DON'T like the smell of the "Stinky Car"... it makes me sick, so I change cars. I DON'T like the smell of horse urine… I assume it's horse… but it bothers me, so I move. The smell of grilling meat is appealing. My allergies act up when I'm out in the park, and the aroma of a premium cigar is wonderful... to me. That's just me. But, this is New York City. We've all managed to live together, next to each other, on top of each other, for over a hundred years. There are things we like and things we don't, but we all still choose to live here, because it's New York City and there's no other place like it. The smells, the sounds, the people… It's what makes New York, New York. This is not a second hand smoke issue… this is a second hand SMELL issue… and we couldn't possibly legislate all the smells in this city… It just smells like New York... and it feels like New York. And I love it.

READ INTO RECORD

ROBERT E. MADDEN, MD, FACS
6 Crows Nest Road, Bronxville, NY 10708
(914) 260-0749

October 14, 2010

Testimony of Robert Madden, MD, FACS
City Council Health and Parks Committee
Int. No. 332
Prohibiting smoking in pedestrian plazas and public parks.

My name is Dr. Robert Madden. I am a faculty member of a medical school in the NYC area. I am a cancer research physician for many years and have held research grants from the National Cancer Institute and the American Cancer Society. I am also a past president of the NY Cancer Society.

My reason for speaking today is to bring some honesty to the debate over the attempt to limit and, quite frankly to prohibit, the use of tobacco products by ordinary citizens of this city and by extension to the entire region. I have been an observer of this movement for several years, but I have become alarmed in more recent years by the zealot-like pressure of the attempts to suppress and destroy an entire industry, an industry that employs thousands of ordinary citizens and produces much needed revenue to municipalities.

This is being done in the name of tobacco being a cause of cancer, emphysema, and a host of ills to mankind, birds and fish. Nothing could be further from the truth. And I am speaking as a physician experienced in the treatment of diseases of the lung and blood vessels. This all started from a well meaning surgeon generals' report in the 1960s, and sputtered for years until the election of Michael Bloomberg in 2001. Using the bully pulpit of the mayor of a large city, and with the help of an ambitious commissioner of health, it was foisted upon the populace who bought it hook, line and sinker.

To me the most offensive element of the smoking bans is the resort to science as "proving that environmental smoke, second hand smoke, causes lung cancer". Not only is this unproven but there is abundant and substantial evidence to the contrary. It is frustrating, even insulting, for a scientist like myself to hear the bloated statistics put out by the American Cancer Society (of which I am a member) and the American Lung Association used to justify what is best described as a political agenda. Smokers enjoy smoking. Most non-smokers are neutral. Anti-smokers hate smoking. It is this last

group that drives the engine of smoking bans. To impose this ban is to deny people of their rights.

Using the superlatives of "the debate is over," and "there is no discussion," all opposition has been silenced. Well, not quite all as we see today! The facts would not stand up to the scrutiny of scientific proof. Many of the "facts" are simply unsubstantiated quotes repeated from governmental reports and with this shaky foundation you'd have an entire industry that supports thousands of taxpayers and voters plowed under and trample upon individual freedom.

Don't let this happen.

READ INTO RECORD

NEW YORK CITY COUNCIL

HEARING on SMOKE-FREE PUBLIC PARKS AND BEACHES – 10/14/10

Testimony Given by: STATEN ISLAND MENTAL HEALTH SOCIETY, INC.

Good afternoon, and thank you for the opportunity to offer testimony about this all-important topic: literally, a life and death issue. I represent the Staten Island Mental Health Society, a large multi-faceted children's and families' service provider, helping to meet the needs of Staten Island families for over one hundred ten years.

You may well ask: "What does a mental health agency have to do with smoking in public spaces?" Don't they have better things to do, given all of the mental health problems out there?" The fact is that our mission encompasses caring about the overall well-being and health of Staten Island's children, adolescents and families. We care very deeply.

You have all been presented with the alarming facts about the seriously devastating physical effects of second-hand smoke – on all of us, but particularly our children, who breathe in 50% more air pollution than adults because their lungs are smaller; or that close to 60% of we non-smoking New Yorkers have an elevated level of cotinine – a nasty by-product of tobacco use – in our blood, a clear indication that we have been exposed to second-hand smoke, despite smoking being banned in most indoor locations.

The Staten Island Mental Health Society serves up to 1000 children – and their families – at any point in time. Over three hundred employees work hard to deliver mental health and substance abuse treatment, Head Start and early childhood intervention programs, child abuse and neglect prevention programs, therapeutic afterschool programs, substance abuse prevention programs, transition to adulthood projects and day treatment services.

Ours is a totally dedicated, community-based and focused organization. This is why we have joined the Smoke-Free Partnership of Staten Island, and the citywide Coalition, in support of smoke-free public health policy. Because we know that there is no mental health, there is no safe transition to adulthood, there is no substance abuse prevention, without physical health and well-being. We work so that Staten Island's children are better able to reach their life goals and to function at their optimal levels:

- Without health risks of second-hand smoke
- Without health problems caused by SHS experienced by parents/caregivers
- Without the inordinate expense of cigarettes when families have limited incomes .

We know that parents and caring adults don't wish to inflict physical harm on children and young people. And yet, even with the clearest evidence of the harm that is inflicted upon children by second

hand smoke appears to hold little sway with a large number of people. We urge all such ambivalent persons to reconsider their positions and place the face of a loved one, particularly the face of a beloved child, at the forefront of their minds as they reconsider their position on this very significant bill.

We are confident that people experience positive effects as a result of standing up, taking a stand, and investing in their families' and communities' environmental health.

Thank you.

Nathalie J. Weeks, LMSW/MBA, Sr. Vice President for Behavioral Health Services

Staten Island Mental Health Society

669 Castleton Avenue

Staten Island, New York 10301

Tel. (718) 442-2225

NEW YORKIC CITY
C.L.A.S.H
Citizens Lobbying Against Smoker Harassment
P.O. Box 1036
Brooklyn, New York 11234
917-888-9317

October 14, 2010

Testimony of Audrey Silk, Founder

NYC Council Health and Parks Committees
Int. No. 332
Prohibiting smoking in pedestrian plazas and public parks

I mostly quote, and with some slight changes, someone else when I say that:

Anti-Smokerism is a crusade that has been inflated by both exaggeration and downright malfeasance, fueled by the awarding of fat grants and salaries to any scientist who'll produce the "right" results.

The Anti-Smoker "scientific" community is a tight clique of like-minded scientists and bureaucrats, who give each other jobs, publish each other's papers -- and conspire to shut out any point of view that threatens to derail their agenda and/or gravy train.

Such behavior from scientists is a travesty.

In the end, grievous harm will have been done not just to individual scientists' reputations, but to the once-sterling reputation of science itself. For that, we will all suffer.

/quote

Count Health Commissioner Farley among them.

Approve this proposal and you will be guilty of foisting an edict upon the public built upon a fraud to satisfy a personal craving that can now only be described as religious in nature, not Public Health.

NYC officials rest most of their case for this ban on two hardly conclusive studies (1, 2) from which the following two talking points, carefully crafted to prey on the ignorant to deceive them to win this game, have emerged:

First: *A person sitting within three feet of a smoker outside can be exposed to levels of secondhand smoke similar to those experienced indoors.*

This lie for effect comes from what's called the Stanford study. As a man of science and key advisory proponent, Dr. Farley must KNOW that without accounting for quantity of cigarettes smoked and duration of exposure this statement is false. The author of this research himself has said, "When the cigarette goes out the smoke is gone, not like in a bar where it hangs around for hours," and admitted the brevity of exposure served to make it inordinately difficult to ascertain the actual health risk.

He chooses to be dishonest with the public by failing to divulge the researcher's *full* conclusion. That is, if you are upwind from a smoker – even if sitting right next to him! -- or six feet away "you'll get no exposure to the outdoor smoke." (3)

Having now been informed of this, if your preference is still to deprive one group of their liberty over advising Walk Away to the other, it becomes perverted on its face considering the country we live in.

Second: *More than half of non-smoking New Yorkers (57%) have elevated levels of cotinine, a by-product of nicotine, in their blood.*

This figure comes from blood tests taken in 2004, thus out-dated, so how do we know it's still true? Yet shhhh, don't tell anyone, right? Honesty sacrificed for the fear effect. Regardless, it's hardly the whole equation and men like Dr. Farley know that. Proof of exposure says absolutely *nothing* about the risk level for <u>harm</u> due to that exposure. The gold standard in toxicology is the Dose Makes the Poison. To quote the CDC itself: "The presence of a chemical in blood or urine does not necessarily indicate that the chemical will cause disease." (4) That goes for exposure to tobacco smoke too. "No safe level" has been no more than a politically motivated statement, not grounded in anything resembling respectable science. To put the statement in question in proper perspective, you might as well say that 57% of NYC residents were caught in the rain without their umbrellas. Okay. How many drowned?

I think you know your entire scientific case for this ban disintegrates upon exposure to sunlight. So why don't you just come clean and end this charade by admitting this has zero to do with protecting anyone from exposure to smoke and all to do with the mayor's and your desire to exert control over an individual's free will to engage in *legal* behavior through coercive governing. The enactment of personal bias into law. It's depraved.

Approve this and soon I'll be here again testifying against your plan to ban smoking in homes. Well I don't think so. This is where we draw the line. It's time to flip the script. The danger is now absolutely you, not me. It's this behavior by government that's toxic

and nasty. It stinks. Compared to what we're witnessing today, cigarette smoke smells like roses. The shame to bear is yours, not mine. There is more dignity in smoking this cigarette than in the game of malice disguised as virtue being played here. The right to be intolerant ends where our civil liberties begin. The informed choice to use a legal product is normal. What you're doing here today is the aberration. When the law is an ass then it's our duty to revolt. Pass this, go ahead. We will not comply and those who respect the promise of freedom and individualism in this country – rather than your self-aggrandizing collectivist ideology of a "healthy city" that you think allows you to turn us into your lab rats -- will give us this pass. You're only deluding yourselves if you think they don't outnumber the squeaky wheels in this room.

Footnotes

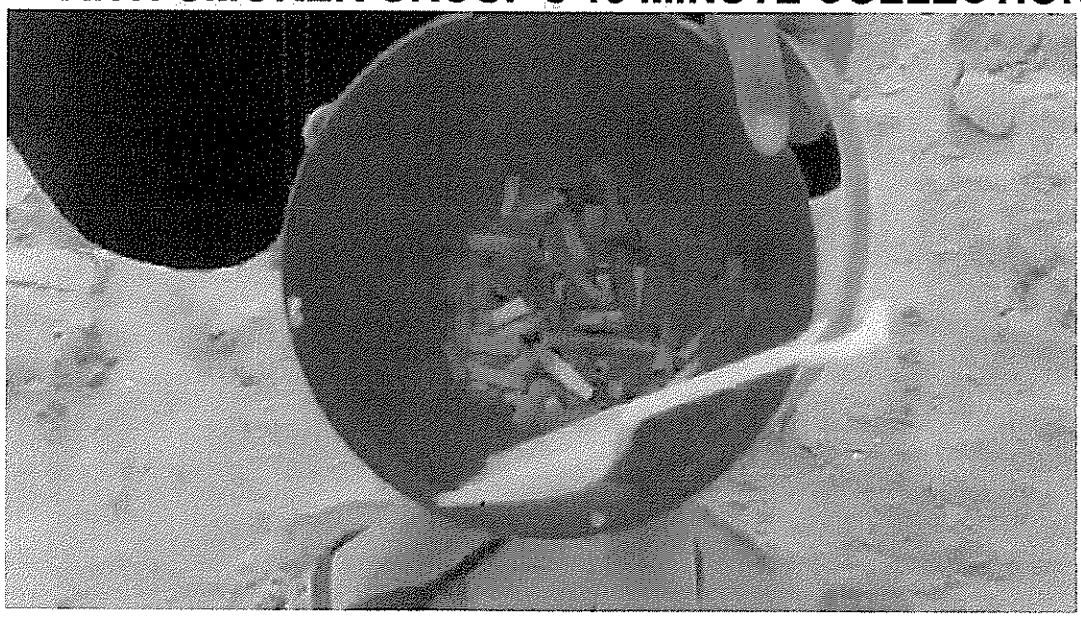
(1) Neil E. Klepeis et al. "Real Time Measurement of Outdoor Tobacco Smoke Particles." Air and Waste Management Association, Volume 57. May 1, 2007 http://www.ashaust.org.au/pdfs/OutdoorSHS0705.pdf

(2) Jennifer A. Ellis, Thomas R. Frieden, et al. "Secondhand smoke exposure among nonsmokers nationally and in New York City." Nicotine Tob Res (2009) 11(4): 362-370 first published online January 1, 2009 doi:10.1093/ntr/ntp021 http://ntr.oxfordjournals.org/content/early/2009/01/01/ntr.ntp021.full.pdf+html

(3) "Outdoor Second Hand Smoke Exposure: Science & Common Sense." WeHoNews.com. February 15, 2010 http://wehonews.com/z/wehonews/archive/page.php?articleID=4460

(4) Centers for Disease Control. Press Release. March 21, 2001.

NYC C.L.A.S.H.'s 15 MINUTE COLLECTION
-VS-
ANTI-SMOKER GROUP's 15 MINUTE COLLECTION



The Health Consequences of Involuntary Exposure to Tobacco Smoke

A Report of the Surgeon General

Secondhand Smoke

what it means to you

DEPARTMENT OF HEALTH & HUMAN SERVICES • USA

CDC

SAFER • HEALTHIER • PEOPLE™

Secondhand Smoke

It hurts you.

It doesn't take much.

It doesn't take long.

The 2006 Surgeon General's report has new information about how breathing secondhand smoke hurts your health. You can find more information about this report by going to the Surgeon General's website at **www.surgeongeneral.gov.**

More information is also available by going to the Centers for Disease Control and Prevention (CDC) website at **www.cdc.gov/tobacco.**

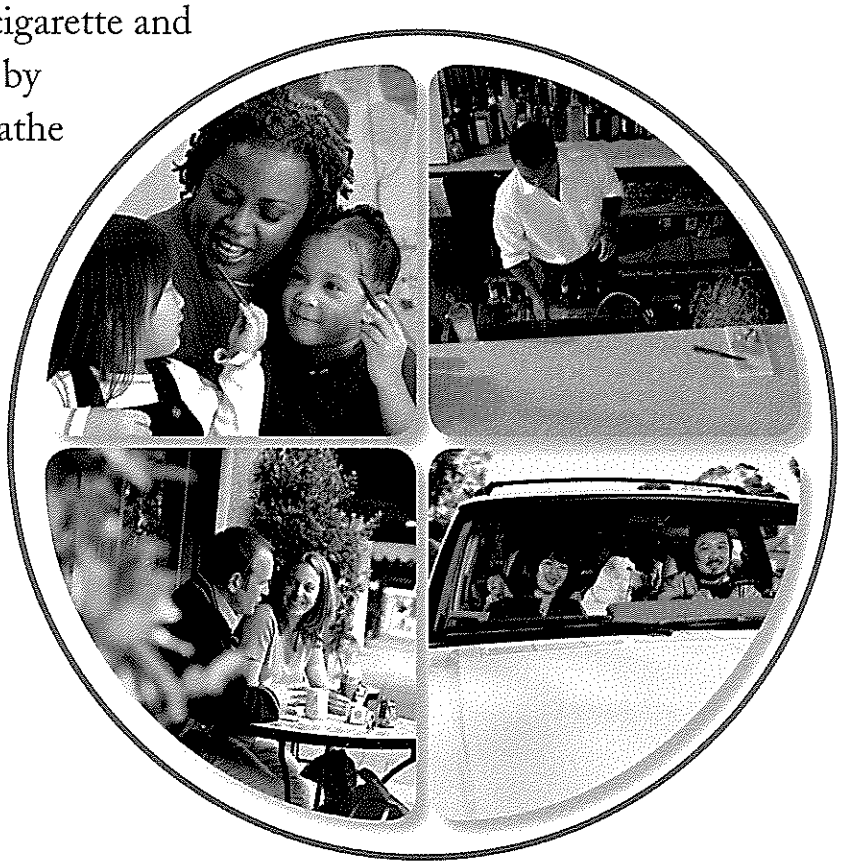
Secondhand smoke is dangerous.

The Surgeon General of the United States, working with a team of leading health experts, studied how breathing secondhand tobacco smoke affects you.

This booklet explains what scientists have learned about the dangers of secondhand smoke. It also tells you how to protect yourself and your family.

What is secondhand smoke?

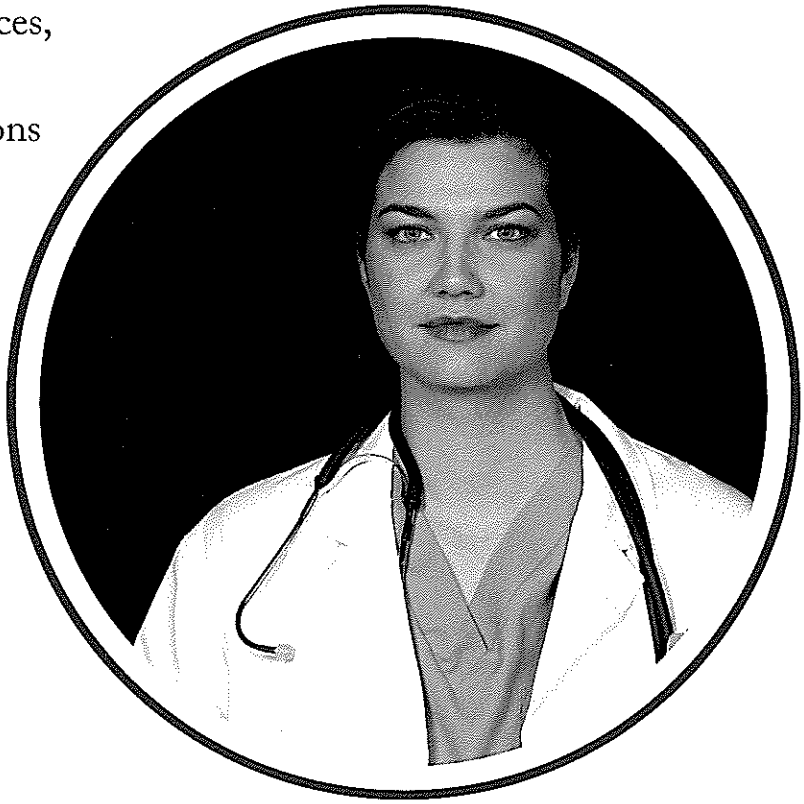
When a person smokes near you, you breathe secondhand smoke. Secondhand smoke is the combination of smoke from the burning end of the cigarette and the smoke breathed out by smokers. When you breathe secondhand smoke, it is like you are smoking.



Whether you are young or old, healthy or sick, secondhand smoke is dangerous.

What we now know:

- There is no safe amount of secondhand smoke. Breathing even a little secondhand smoke can be dangerous.
- Breathing secondhand smoke is a known cause of sudden infant death syndrome (SIDS). Children are also more likely to have lung problems, ear infections, and severe asthma from being around smoke.
- Secondhand smoke causes heart disease and lung cancer.
- Separate "no smoking" sections DO NOT protect you from secondhand smoke. Neither does filtering the air or opening a window.
- Many states and communities have passed laws making workplaces, public places, restaurants, and bars smoke-free. But millions of children and adults still breathe secondhand smoke in their homes, cars, workplaces, and in public places.

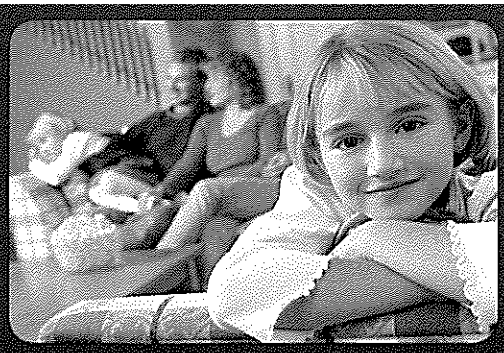


No amount of secondhand smoke is safe.

When you are around a person who is smoking, you inhale the same dangerous chemicals as he or she does. Breathing secondhand smoke can make you sick. Some of the diseases that secondhand smoke causes can kill you.

Protect yourself: do not breathe secondhand smoke. But completely avoiding secondhand smoke is very hard to do. Most of us breathe it whether we know it or not. You can breathe secondhand smoke in restaurants, around the doorways of buildings, and at work. When someone smokes inside a home, everyone inside breathes secondhand smoke. Some children even breathe smoke in day care.

There is no safe amount of secondhand smoke. Children, pregnant women, older people, and people with heart or breathing problems should be especially careful. Even being around secondhand smoke for a short time can hurt your health. Some effects are temporary. But others are permanent.



WHAT CAN YOU DO?

Make your environment smoke-free.

- *Make your home and car smoke-free.*
- *Visit smoke-free restaurants and public places.*
- *Ask people not to smoke around you and your children.*

Secondhand smoke contains poisons.

The chemicals found in secondhand smoke hurt your health and many are known to cause cancer. You breathe in thousands of chemicals when you are around someone who is smoking.

WHAT THE SCIENCE SAYS

How do scientists measure exposure to secondhand smoke?

Researchers measure

- how many people are smoking
- how many cigarettes they smoke
- time spent in the room
- levels of nicotine in the air, and
- levels of nicotine by-products in the body

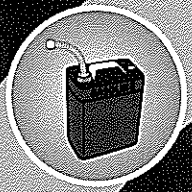
Secondhand Smoke
is toxic

Cancer Causing Chemicals
All are extremely toxic

Toxic Metals
Can cause cancer
Can cause death
Can damage the brain and kidneys

Formaldehyde
Used to embalm dead bodies

Chromium
Used to make steel



Benzene
Found in gasoline

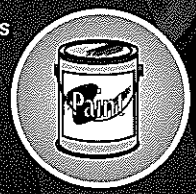
Arsenic
Used in pesticides

Secondhand smoke has more than 4,000 chemicals.

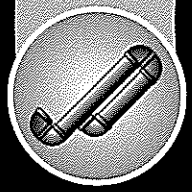
Many of these chemicals are toxic and cause cancer.

You breathe in these chemicals when you are around someone who is smoking.

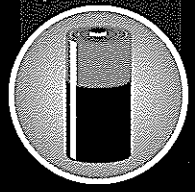
Polonium 210
Radioactive and very toxic



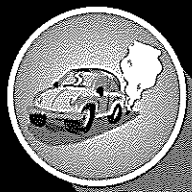
Lead
Once used in paint



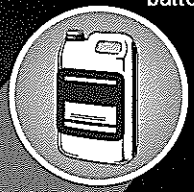
Vinyl Chloride
Used to make pipes



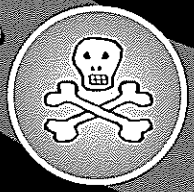
Cadmium
Used in making batteries



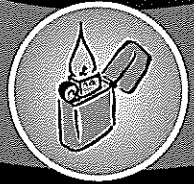
Carbon Monoxide
Found in car exhaust



Toluene
Found in paint thinners



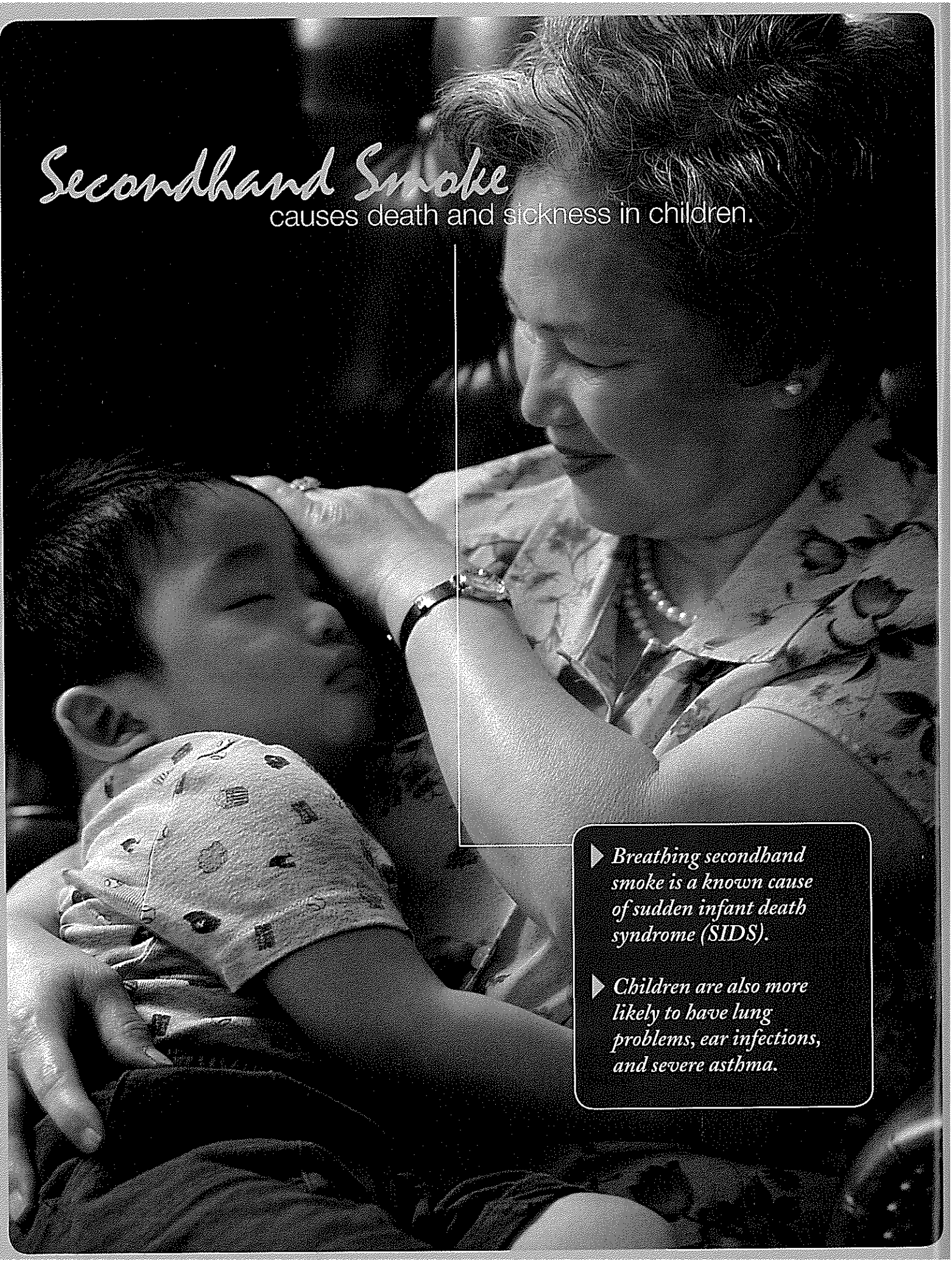
Hydrogen Cyanide
Used in chemical weapons



Butane
Used in lighter fluid

Ammonia
Used in household cleaners

Poison Gases
Can cause death
Can affect heart and respiratory functions
Can burn your throat, lungs, and eyes
Can cause unconsciousness


Secondhand Smoke
causes death and sickness in children.
Breathing secondhand smoke is a known cause of sudden infant death syndrome (SIDS).
Children are also more likely to have lung problems, ear infections, and severe asthma.

Babies are hurt by secondhand smoke.

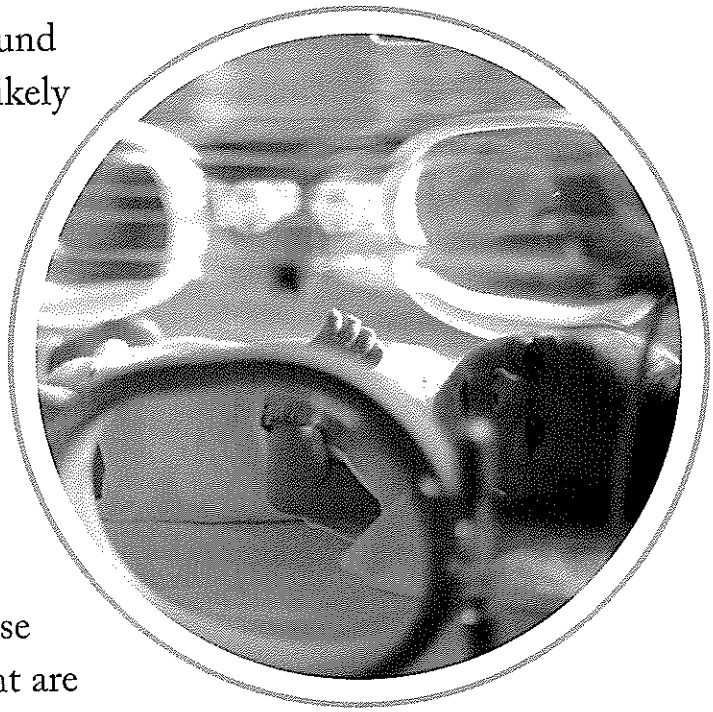
Tobacco smoke harms babies before and after they are born. Unborn babies are hurt when their mothers smoke or if others smoke around their mothers. Babies also may breathe secondhand smoke after they are born. Because their bodies are developing, poisons in smoke hurt babies even more than adults. Babies under a year old are in the most danger.

Secondhand smoke is a known cause of sudden infant death syndrome (SIDS).

The sudden, unexplained, unexpected death of an infant before age 1 year is known as SIDS. The exact way these deaths happen is still not known. We suspect it may be caused by changes in the brain or lungs that affect how a baby breathes. During pregnancy, many of the compounds in secondhand smoke change the way a baby's brain develops. Mothers who smoke while pregnant are more likely to have their babies die of SIDS.

Babies who are around secondhand smoke—from their mother, their father, or anyone else—after they are born, are also more likely to die of SIDS than children who are not around secondhand smoke.

Secondhand smoke causes low birth weight and lung problems in infants.



Babies whose mothers are around secondhand smoke are more likely to have lower birth weights. These babies can have more health problems because they breathe smoke. For example, they are more likely to have infections than babies who are not around secondhand smoke.

Studies show that babies whose mothers smoke while pregnant are more likely to have lungs that do not develop in a normal way. Babies who breathe secondhand smoke after birth also have weaker lungs. These problems can continue as they grow older and even when they become adults.

WHAT THE SCIENCE SAYS

The main place young children breathe secondhand smoke is in their homes. Almost 3 million children in the United States under the age of 6 years old breathe secondhand smoke at home at least 4 days per week.

Older children are in danger, too. Studies show that older children whose parents smoke get sick more often. Like babies, their lungs grow less than children who do not breathe secondhand smoke. They get more bronchitis and pneumonia. Wheezing and coughing are also more common in children who breathe secondhand smoke.

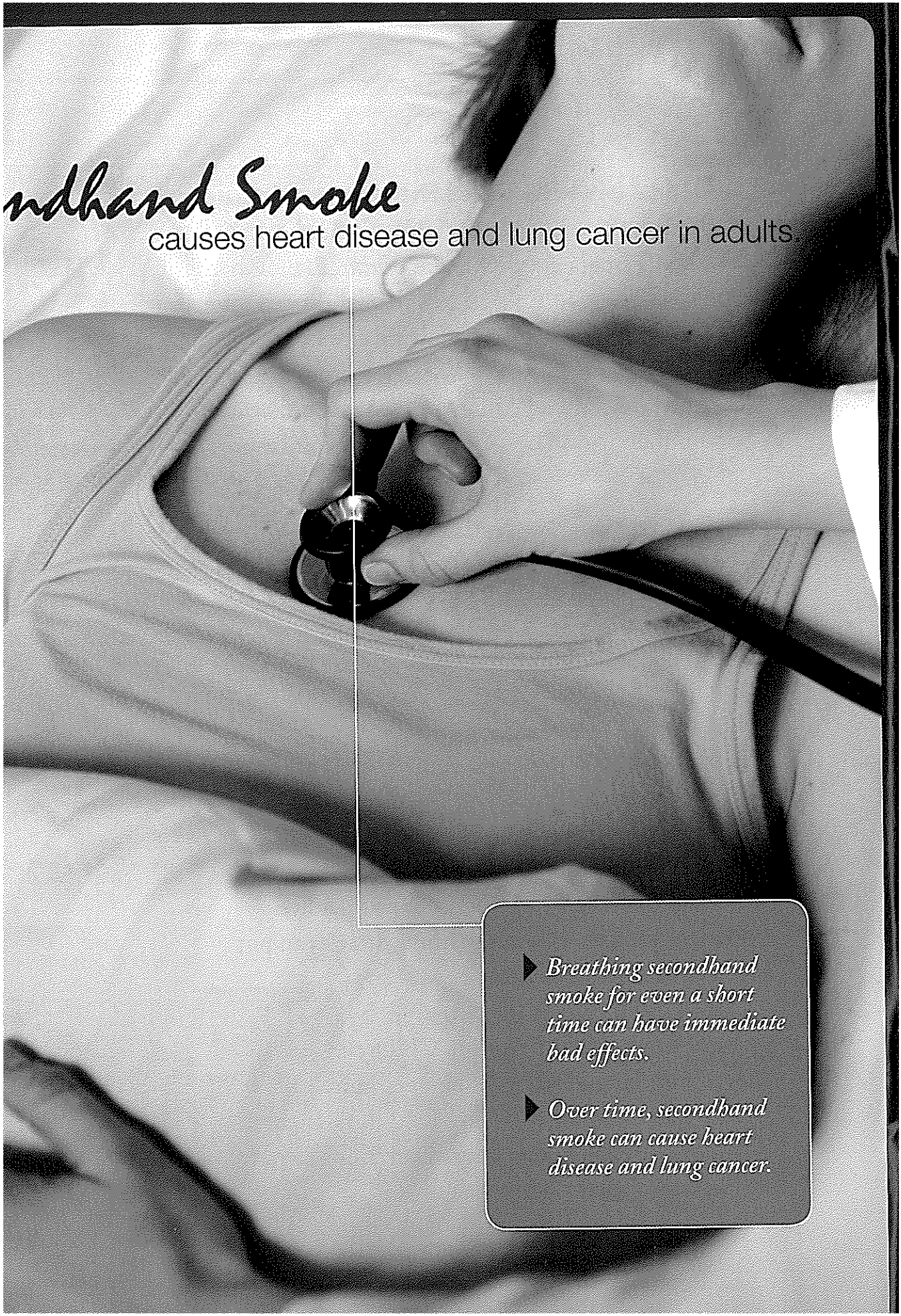
Secondhand smoke can trigger an asthma attack in a child. Children with asthma who are around secondhand smoke have worse asthma attacks and have attacks more often. More than 40 percent of children who go to the emergency room for asthma live with smokers. A severe asthma attack can put a child's life in danger.

Ear infections are painful. Children whose parents smoke around them get more ear infections. They also have fluid in their ears more often and have more operations to put in ear tubes for drainage.

WHAT CAN PARENTS DO?

Protect your children's health.

- *Do not allow anyone to smoke near your child.*
- *Do not smoke or allow others to smoke in your home or car. Opening a window does not protect your children from smoke.*
- *Use a smoke-free day care center.*
- *Do not take your child to restaurants or other indoor public places that allow smoking.*
- *Teach older kids to stay away from secondhand smoke.*


ndhand Smoke
causes heart disease and lung cancer in adults.
Breathing secondhand smoke for even a short time can have immediate bad effects.
Over time, secondhand smoke can cause heart disease and lung cancer.

noke hurts adults

round secondhand
ly it is to hurt you.

:athe smoke at home
ikely to become sick
sease and lung cancer.
:ondhand smoke may
seases, too.

noke is bad for

d smoke makes the
d behave like those
ven a short time in
your blood platelets
ondhand smoke also
your blood vessels. In
changes can cause a

anges how your heart,
els work in many ways.
hours of secondhand

WHAT CAN YOU DO?

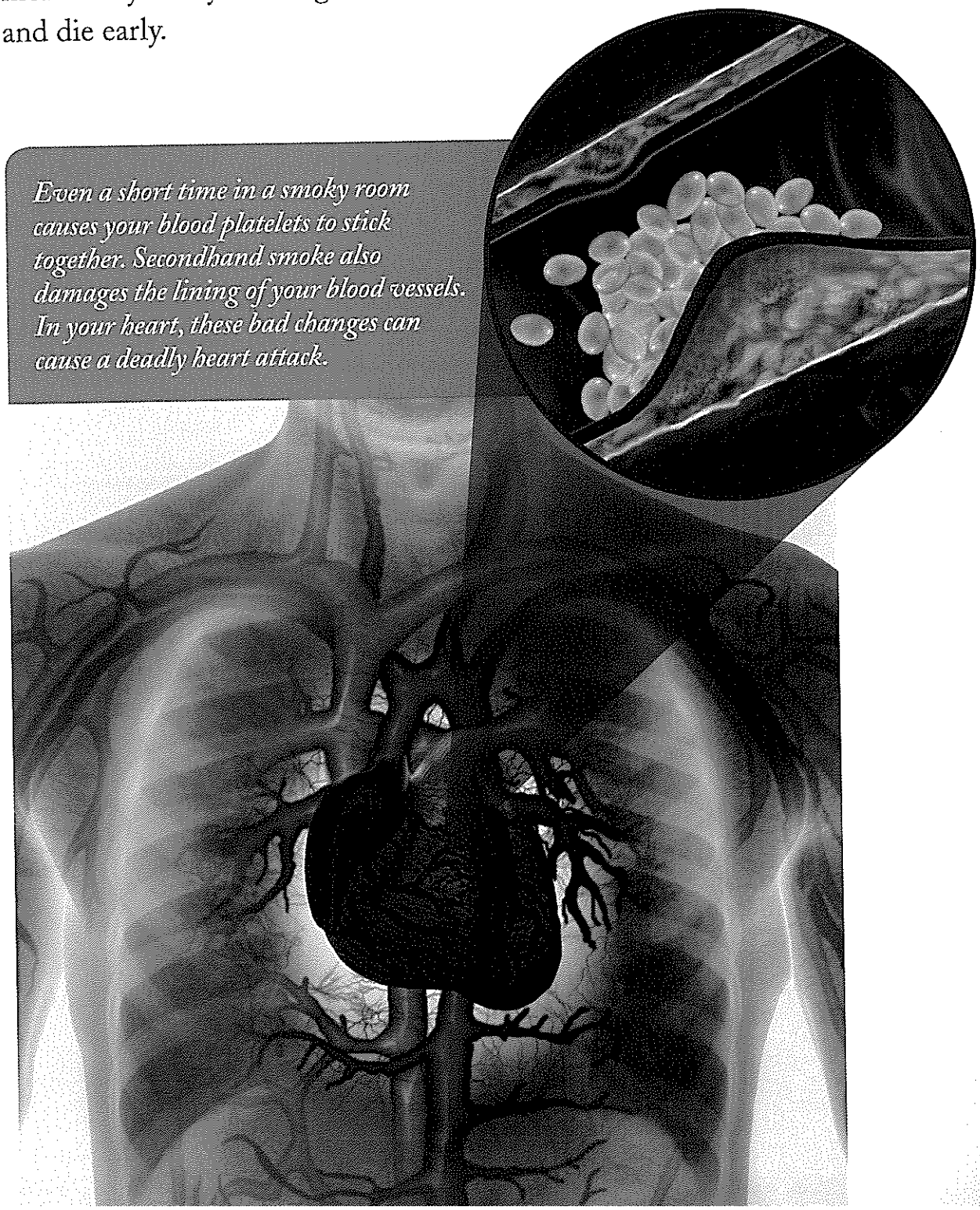
Protect your health.

More restaurants and bars are smoke-free than ever. New York City restaurants and bars increased business by 9 percent after becoming smoke-free.

- *Choose restaurants and bars that are smoke-free. Thank them for being smoke-free.*
- *Let owners of businesses that are not smoke-free know that smoke bothers you. Tell*

People who have heart disease should be very careful not to go where they will be around secondhand smoke.

The bottom line is that breathing secondhand smoke makes it more likely that you will get heart disease, have a heart attack, and die early.



Even a short time in a smoky room causes your blood platelets to stick together. Secondhand smoke also damages the lining of your blood vessels. In your heart, these bad changes can cause a deadly heart attack.

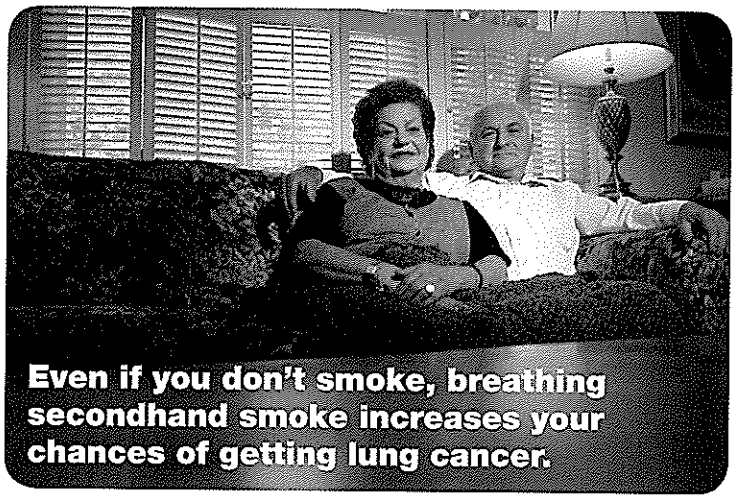
Secondhand smoke hurts your lungs.

Secondhand smoke includes many chemicals that are dangerous for your lungs. Secondhand smoke is especially dangerous for young children and adults with heart and lung disease.

Secondhand smoke causes lung cancer.

Secondhand tobacco smoke contains the same cancer-causing chemicals that smokers inhale.

Secondhand smoke causes lung cancer in adults who don't smoke. Breathing in secondhand smoke at home or work increases your chances of getting lung cancer by 20 percent to 30 percent.



Even if you don't smoke, breathing secondhand smoke increases your chances of getting lung cancer.

WHAT CAN HEALTH CARE EXPERTS DO?

- *Ask patients if they smoke and if they are around secondhand smoke.*
- *Advise patients who smoke to stop, and help them quit.*
- *Advise patients who smoke not to smoke around others.*
- *Advise nonsmokers to protect themselves by avoiding all secondhand smoke.*
- *Remind parents to protect their children from secondhand smoke.*
- *Discuss the added dangers of secondhand smoke for adults who have heart disease or asthma.*
- *Offer special warnings to parents when treating children with respiratory infections, asthma, or ear disease.*

WHAT CAN EMPLOYERS DO?

Protect your workers.

Secondhand smoke is harmful for all workers. Restaurant and bar workers breathe more secondhand smoke than other workers and have higher rates of lung cancer.

- *Make sure your employees do not breathe secondhand smoke at work.*
- *Make all indoor places smoke-free.*
- *Don't allow smoking near doorways and entrances.*
- *Offer programs to help employees quit smoking.*

Secondhand smoke causes other breathing problems.

Secondhand smoke affects how well your lungs work, especially if you already have asthma or other breathing problems. Being around smoke makes you more congested and cough more.

Secondhand smoke also irritates your skin, eyes, nose, and throat. If you have allergies or a history of breathing problems, secondhand smoke can make you even sicker.

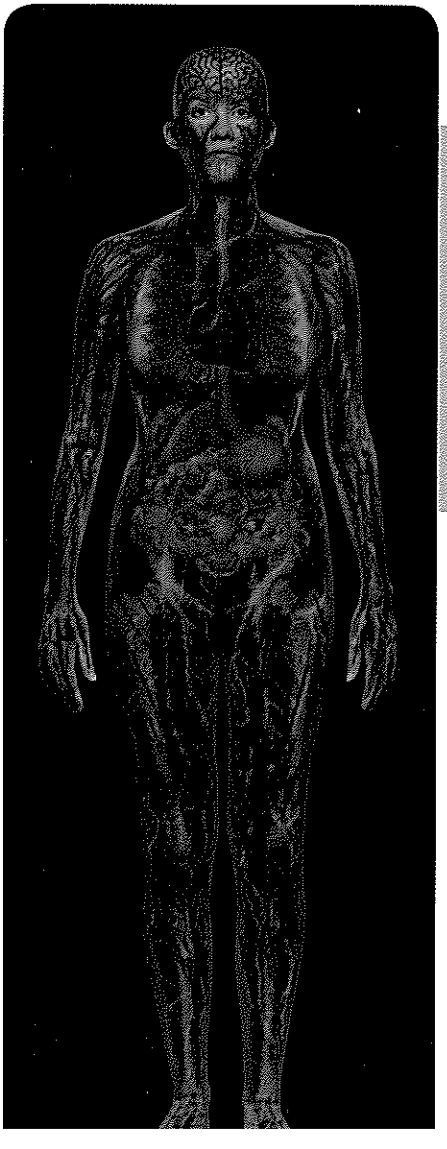
WARNING

You should especially speak to your doctor or healthcare provider about the dangers of secondhand smoke if:

- **You have breathing or heart problems**
- **You are pregnant**
- **You are concerned about your children's health**

Secondhand smoke may cause disease in other parts of your body.

We know that smoking causes many forms of cancer. Scientists believe even a little tobacco smoke is dangerous. Scientists also believe secondhand smoke may cause other diseases throughout your body. They are doing studies on possible links to stroke, breast cancer, nasal sinus cancer, and chronic lung problems in children and adults.



Secondhand smoke may cause disease in other parts of your body.

There's no such thing as a

NO SMOKING

section

No amount of secondhand smoke is safe.

Here are some unexpected ways you may breathe secondhand smoke every day:

Sitting in the "no smoking" section, even if it doesn't smell smoky

Riding in a car while someone else is smoking, even if a window is open

Being in a house where people are smoking, even if you're in a another room

Working in any restaurant, warehouse, or building that allows smoking inside, even if there is a filter or ventilation system

Acknowledgments

This public document was prepared by the U.S. Department of Health and Human Services under the direction of the Office of the Surgeon General to make information in *The Health Consequences of Involuntary Exposure to Tobacco Smoke: A Report of the Surgeon General* available to everyone.

Richard H. Carmona, M.D., M.P.H., F.A.C.S., Surgeon General, U.S. Public Health Service, Office of the Surgeon General, Office of the Secretary, Washington, D.C.

Kenneth P. Moritsugu, M.D., M.P.H., Deputy Surgeon General, U.S. Public Health Service, Office of the Surgeon General, Office of the Secretary, Washington, D.C.

A special thanks to the many people who provided expert advice and suggestions: Dr. Jonathan Samet, Senior Scientific Editor of the 2006 Surgeon General's report and Professor and Chairman, Department of Epidemiology, Bloomberg School of Public Health, Johns Hopkins University; Dr. Karen Near, Senior Science Advisor, Office of the Surgeon General, DHHS; Ellen Field, Deputy Assistant Secretary, DHHS; Dr. Terry Pechacek, Associate Director for Science, Office on Smoking and Health, CDC; Leslie Norman, Managing Editor of the 2006 Surgeon General's report, CDC; Dana Shelton, Associate Director for Policy, Planning and Coordination, Office on Smoking and Health, CDC; Peggy Williams, Writer-Editor, Quantell, Inc.; Gabrielle Robinson, Writer-Editor, Northrop Grumman; the CDC Health Literacy Workgroup; Dr. P. Lynne Stockton, CDC; Victoria Barnard, Teacher, Chamblee High School; Tommy Jones, Reviewer; and the scientific and communications staff of the Office on Smoking and Health, CDC.

Project Leads, Writers, and Editorial Assistance
Sarah Gregory, Health Communications Specialist, CDC
Peter Xiques, Writer, Science Applications International Corporation
Vickie Reddick, Writer, Science Applications International Corporation

Graphic Design
C. Mark Van Hook, Graphic Designer, Science Applications International Corporation

About
the Surgeon General's Report

The Surgeon General is the nation's highest-ranking health officer. The President appoints the Surgeon General to help promote and protect the health of all Americans.

The Surgeon General gives Americans the best scientific information available on how to improve their health and reduce their risk of illness and injury.

The Health Consequences of Involuntary Exposure to Tobacco Smoke: A Report of the Surgeon General was prepared by many of the country's leading scientists and public health experts. The full report is more than 600 pages long. It took more than 4 years to complete. It is written for a scientific audience. However, Surgeon General Richard H. Carmona believes the findings are very important to everyone.

Suggested Citation: U.S. Department of Health and Human Services. *The Health Consequences of Involuntary Exposure to Tobacco Smoke: A Report of the Surgeon General. Secondhand Smoke What It Means to You.* U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, Coordinating Center for Health Promotion, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health, 2006.

Secondhand Smoke

It hurts you.

It doesn't take much.

It doesn't take long.

To download copies of this booklet or the full Surgeon General's report, *The Health Consequences of Involuntary Exposure to Tobacco Smoke: A Report of the Surgeon General*, go to **www.cdc.gov/tobacco**. To order single copies of these documents, call toll free **1-800-CDC-INFO**.

For more information

For more information on secondhand smoke, talk to your doctor, nurse, pharmacist, or other healthcare professional.

More information about the Surgeon General's report is available on the Surgeon General's website at

www.surgeongeneral.gov

More facts and advice are available from
Centers for Disease Control and Prevention
www.cdc.gov/tobacco
Toll free: **1-800-CDC-INFO** (1-800-232-4636)
In English, en Español
24 hours/day, 7 days/week
Text telephone for hearing impaired: **1-888-232-6348**
Other helpful information is available at www.smokefree.gov.
To access a telephone quitline serving your area, call
1-800-QUIT-NOW (1-800-784-8669).

for the Record

Good afternoon ladies and gentlemen, my name is Collin Pelle and I am here to talk to you about smoking. What is the message that we are sending by smoking? Have we thought about that! I guess not! What does smoking really mean to you? Well to me, though smoking will kill you, we make the choice of killing ourselves. I know society uses smoking as a way to calm or cope with everyday stress or challenges, but really think about it. Is it worth your life or even your children's lives? I think not.

I know these facts because I have witnessed the effects that smoking causes. Smoking is a known cause of Lung Cancer, Emphysema, and (COPD) and the Question is why do we do this to ourselves? I have even witnessed young adults And teenagers habitually smoke from a very young age. I believe smoking is Passed on by family and or friends. It has been known as something cool to do. 90% of young children and teenagers are known to do what they see is being done by adults. So if they see you smoking what do you think the most likely outcome will be? So I wanted to come to speak you today to share my point of view as a young adult who is influenced by friends, family and most of all by society so then ask yourself how did I avoid falling into the pitfall of smoking? I believe it has been my ability to see past the hype and see what I want for my future and it isn't smoking.

Testimony of J. Glynn Loope, Executive Director
Cigar Rights of America
October 14, 2010
Before the Joint Meeting of the New York City Council
Committee on Health and Committee on Parks and Recreation

Members of Council and of the Committees, thank you for this opportunity to address the proposed ban on smoking in pedestrian plazas and public parks within New York City. I represent Cigar Rights of America, a national advocacy organization for cigar enthusiasts, with partners in the manufacturing and retail tobacconist sectors, as well.

In a national context, the State of New York and New York City specifically ranks among our largest areas for membership, as our members patron some of great cigar shops in the world, right here in New York City.

We would submit that this proposal is based more upon political hype and public relations zeal, than on scientific evidence and a true concern for the public health. It's a brand of 'flavor of the month politics,' that seeks to divert attention from the actual pressing issues of the day for citizens in New York City.

In a public health context, this proposal will not prevent one case of cancer, one case of asthma, one heart attack, or prevent one person from partaking in perfectly legal tobacco products. It is advocated by a city Health Department that used public funds to produce a pamphlet on how to safely use heroin. This is a clear case of misplaced priorities.

I realize how these types of proposals sound like motherhood and apple pie; that it's all for the good of the general public; and that it somehow makes a governing body sound as if it is being 'progressive.'

In fact, you would be making bad public policy, based upon questionable science, without a thorough review of all studies surrounding such issues, which provide a more objective view of tobacco use, and outdoor smoking more specifically.

There are others that have. We highlight the City of Athens, Georgia. As they considered an outdoor smoking ban, they learned that no peer review study existed. They consulted with the University of Georgia-Athens, and its renowned environmental health sciences department.

The head of that department stated regarding exposure to outdoor second hand smoke, "Is this of public health concern? Do these levels pose a risk? We haven't answered that yet." Based upon that, the local governing body stated that it would not be tackling the issue without more evidence.

We would also point to the analysis within the journal of Toxicology and Pharmacology, which stated regarding Mainstream and Environmental Tobacco Smoke (ETS): "It should be clear that the seemingly insurmountable difficulties in measuring ETS exposures and doses, unresolved classification bias, and the inability to control for numerous independent confounders explain the inconsistency of weak ETS epidemiologic results and speak against the scientifically credible conclusions about a risk that, if real at all, remains imponderable." [Report Submitted for the Record.]

Or, the British Medical Journal submitted analysis, which stated, "The association between environmental tobacco smoke and coronary heart disease and lung cancer may be considerably weaker than generally believed." [Report submitted for the Record.]

Or, the report of the Congressional Research Service which concluded, at best, that further analysis is needed before any credible policies can be objectively developed, as it cited the two largest U.S. studies on this subject, where within these reports, one found a single case of positive risk that was barely statistically significant, and the other no risk at all." [Report submitted for the Record.]

And, the view of Dr. Michael Siegel of the Boston University School of Public Health, where he recently stated regarding this very proposal, "The argument does not extend to wide open spaces like Central Park and hundreds of other large parks in New York City where there is plenty of room for nonsmokers to walk away from someone who is smoking." [Article submitted for the Record.]

But let's take the health debate out of the equation. What about the question of basic fairness to those which decide to use perfectly legal tobacco products, such as cigars, outdoors? Many of these are residents, taxpayers, voters, or travelers and tourists that contribute to the city economy, just like anyone else. Should they not have the same access and ability to use these public resources, while enjoying legal products, and behaving within the bounds of existing law? Of course they should.

In this vain, we would hope you would consider the position and recent action of California Governor Arnold Schwarzenegger, as he vetoed a virtually identical piece of legislation, in a state not known for being 'tobacco friendly.' For a proposal that also would have banned smoking in public parks and upon public beaches, the Governor stated, "There is something inherently uncomfortable about the idea of the state encroaching in such a broad manner on the people…"

The proposed ordinance states that the Department of Parks and Recreation shall have the power to enforce the policy. From a purely public safety context, if Parks and Recreation staff have such 'police powers' and as actual New York City police officers patrol in Times Square where smoking would become illegal, I would much rather their minds be on identifying a Faisal Shahzad, than a pedistrian with a cigar. We have also read of 'self policing' as a characteristic of this ordinance. Do we really want to start pitting city residents against each other in this fashion? Again, a case of misplaced priorities.

If a policy at all is to be considered, then let's find some common ground. First, we believe this entire proposal should be defeated, but we also know that governing should be the art of compromise. Smoking should not be allowed around children, so establish non-smoking areas near playgrounds, where those underage frequent. Forcing the "coralling" of smokers into an isolated area only exacerbates such problems, and also forces those that enjoy legal tobacco products onto the city's already crowded sidewalks.

Your consideration of these sentiments and submitted documents is appreciated. We hope you defeat the proposal, or at least, consider options that take into account the needs and wishes of all – all – New Yorkers, and those that enjoy this great city.

TESTIMONY BEFORE JOINT PUBLIC HEARING OF THE HEALTH AND PARKS AND RECREATION COMMITTEES OF THE COUNCIL / NYC / THURSDAY, 14.X.10

From: **Howard Yourow** (hcyourow@msn.com)
Sent: Thu 10/14/10 7:41 AM
To: hcyourow@msn.com

TESTIMONY BEFORE JOINT PUBLIC HEARING OF THE HEALTH AND PARKS AND RECREATION COMMITTEES OF THE COUNCIL / NYC / THURSDAY, 14.X.10

CouncilMembers :

Thank You for the opportunity to address you this afternoon -- however briefly -- on the important issue of the proposed passage of new legislation banning the smoking of legal tobacco products in The Great Out-of-Doors within the confines of our Great Metropolis.

Simply put : While I, for one, as a public law scholar and educator, concerned citizen and civic advocate -- and occasional smoker -- do harbor serious personal doubt as to the constitutionality of such a ban within a classically liberal or ' libertarian ' scheme of ' ordered liberty ', based both on theories of the positive affirmation of rights as well as restriction on the reach, that is, on the breadth and depth, of the police power, I am at one and the same time well aware that the weight of American judicial opinion supports the prevailing political and legislative trend on the question.

Therefore, I would urge that the politicalegislative process do its best to tailor and proportion such a ban in order to create designated smoking areas within all public spaces which may fall under such a ban, thus recognizing and protecting the rights of those who choose to smoke outdoors, as they have done in this jurisdiction and its predecessors for centuries, while at one and the same time recognizing and protecting the rights of those who choose not to come into contact with any smoke produced -- at least by tobacco products ! This, it seems to me, is a reasonable contemporary compromise which acknowledges that a civilized society, through its legislative processes, seeks as a primary goal, in-and-of-itself, successfully to accommodate the interests of competing factions, in this case the rights of smokers as well as non-smokers to share public space in the common out-of-doors.

Thank You for your time and attention, and I am happy to engage in dialogue with you should there be any questions regarding my statement.

Howard Charles Yourow, SJD
HCYourow@msn.com

From: **Howard Yourow** (hcyourow@msn.com)
Sent: Thu 10/14/10 7:41 AM
To: hcyourow@msn.com

TESTIMONY BEFORE JOINT PUBLIC HEARING OF THE HEALTH AND PARKS AND RECREATION COMMITTEES OF THE COUNCIL / NYC / THURSDAY, 14.X.10

CouncilMembers :

For the Record

Testimony before The City Council Health Committee Hearing on Intro 332/2010-
Legislation to make NYC Parks, Beaches and Pedestrian Plazas Smoke-Free

October 14, 2010

My name is Laila Modzelewski, I am the coordinator of Take Care Staten Island, part of the Take Care New York Initiative.

Tobacco kills more New Yorkers each year than AIDS, drugs, homicide and suicide combined. Staten Island has the highest smoking rates out of all the five boroughs with 19.4 % of Staten Island adults who are smokers. We also have the highest rate of youth smokers at 15.5%. One way to change these alarming statistics is to denormalize smoking and sending the message to our youth that smoking is not a socially acceptable behavior. Passing legislation to make NYC's parks, beaches and pedestrian plazas smoke-free sends the message loud and clear to our youth that smoking is not acceptable.

I am thrilled that City Council is proposing to make NYC's Parks, Beaches and Pedestrian Plazas smoke-free. We all want to live long healthy lives and we know that smoking and secondhand smoke causes numerous preventable diseases. Let's take a step towards being a healthier New York by keeping our parks and beaches smoke-free.

Thank you,

Laila Modzelewski
Take Care Staten Island Coordinator

For the Record

Buenas Tardes. Mi nombre es Maria Elena Khochaiche y soy miembro de Se Hace Camino Nueva York. Estoy aquí para apoyar la propuesta de que los parques y las playas sean libres de humo. El humo nos afecta a todos. Por ejemplo, más de la mitad - 57% - de los neoyorquinos que no fuman tienen niveles elevados de nicotina en la sangre. [redacted] tiene un impacto aun más fuerte en los niños. En Bushwick, donde [redacted] vivo, los niveles de asma son muy altos y el humo es una de las cosas que provoca el asma. Los niños no [redacted] fumar pero les afecta el humo de otras personas. Cuando un niño se enferma del asma o de un problema respiratorio y no puede ir a la escuela, eso le afecta a la educación. Los niños son nuestro futuro y tenemos que cuidarlos. Por eso tenemos que tener los parques y las playas libres del humo y todos tóxicos que causan problemas de salud. Muchas gracias.

Good afternoon. My name is Maria Elena Khochaiche and I'm a member of Make the Road NY. I'm here to support the proposal to have smoke-free parks and beaches. Second-hand smoke affects us all. For example, more than half of non-smoking New Yorkers - 57% - still have elevated levels of nicotine in their blood. But it has an even more negative impact on children. In Bushwick, where I live, there are very high levels of asthma, and second-hand smoke is an asthma trigger. Children don't decide to smoke, but they're impacted by other people smoking around them. When a child gets sick and can't go to school because of asthma or a respiratory problem, it affects their education. The children are our future and we have to take care of them. That's why we need parks and beaches to be smoke-free and free of any other toxics that cause health problems. Thank you.

301 GROVE STREET
BROOKLYN, NY 11237
TEL 718 418 7690
FAX 718 418 9635

92-10 ROOSEVELT AVENUE
JACKSON HEIGHTS, NY 11372
TEL 718 565 8500
FAX 718 565 0646

479 PORT RICHMOND AVENUE
STATEN ISLAND, NY 10302
TEL 718 727 1222
FAX 718 981 8077

WWW.MAKETHEROADNY.ORG

Georgette Negouai
Queens Community House
Testimony on Intro 332
Smoke free Public Parks, Beaches & Pedestrian Plazas
October 14, 2010

My husband started smoking before our marriage. He would even force me to smoke with him. However I refused. He would smoke in bed, and one day set my hair on fire.

When my husband reached the age of sixty, his health began to get really bad. Soon the doctors diagnosed with him lung cancer. He was so ill that he could not breathe. He had to live on oxygen. It was very hard for my family. We watched him die.

My husband was the victim of the tobacco industry. This industry does not care about us and our health. They did not care about the health of my husband who died for no good reason.

I am speaking today because I want people to know that smoking killed my husband. I blame the tobacco industry for his death. I want to make sure no one else suffers like my husband.

I am here also to speak for the future of our children. I want to protect them from both smoking and second hand smoking. We do not want to sacrifice our children any more. If I speak up, I will help save them.

Testimony in Opposition to Outlawing Tobacco Smoking in NYC Parks and Beaches - 10/14/10

Stephen Helfer
3 Crawford St. #8
Cambridge, MA 02139
shelfer@gmail.com

I oppose outlawing tobacco smoking at the city's and beaches for two reasons:

First such a prohibition will unfairly discriminate against the poor, the homeless, and the mentally ill. According to The New York Times (1/18/10) persons living below the poverty level are 60 percent more likely to smoke than more affluent Americans and a Harvard study found that almost 44% of cigarettes sold in the U.S. are purchased by the mentally ill.

Banning smoking at parks and beaches will drive many less privileged New Yorkers from what little refuge they have. While I don't believe that is the intent of this bill's sponsor's, the war on smoking is a war executed by the chattering classes against those they believe to be their social inferiors.

Proponents say they want to protect non-smokers from secondhand smoke, but there seems to be more. Commissioner Farley is quoted in the NY Post (10/14/10) saying he does not believe children should have to even see people smoking. Does he really feel that a habit engaged in by almost 47 million adult Americans, including the President, is so reprehensible that public health officials need to protect children from the sight of smoking? Might he also wish to protect children from seeing fat people or even abnormally thin people.

A much talked about 2007 study found that sitting outside within 3 feet of 8-20 cigarettes being smoked could produce high, but very brief, secondhand smoke exposures. How often does someone city in park next to that many smokers for enough time to be so exposed. One can always move.

Australian public health professor Simon Chapman is one of the most noted anti-smoking specialists in the world and the winner of the WHO World No Tobacco Day medal. In his paper, "Going Too Far...", where he opposes park and beach smoking bans he notes," The 2006 US Surgeon General's report on involuntary exposure to tobacco smoke made no recommendations and reviewed no evidence in its 709 pages on the dangers of outdoor exposure or the public health importance of controlling it. There should be a lesson in that for all of us,

I believe the NYC Council should follow Professor Chapman's recommendation and reject outlawing smoking at city parks and beaches.

October 14, 2010,

Good Afternoon,

My name is Lisette Lopez; I work for Highbridge Community Life Center, a not-for-profit organization located in the Highbridge section of the Bronx. Highbridge Community Life Center has been in the community for 30 years. During my 19 years of employment with a Highbridge I have learned to get involved in the community and speak for the greater good. I come here today to speak of our support for the City Council intro 0332-2010. I would like to share my own personal experience. I am a healthy, non-smoking, Latina woman with three children. I have never been diagnose with any kind of respiratory condition however, when I am close to someone who is smoking or when a heavy smoker comes within close proximity of me, my chest begins to tighten and I become very nauseous . I feel if I experience these reactions from cigarette smoke, others may experience them too. Why subject people especially children in parks or beaches with these hazardous and harmful fumes. So please pass the city council intro 0332-2010 for a healthier environment today and healthier you tomorrow.

Thank you

Lisette Lopez

NYC COUNCIL HEALTH COMMITTEE
PUBLIC HEARING
OCTOBER 14, 2010

GOOD AFTERNOON,

MY NAME IS PHIL KONIGSBERG, AND I'M HERE TO SPEAK IN FAVOR OF INTRO 322 WHICH WOULD IMPROVE THE QUALITY OF LIFE FOR MY FAMILY AND FELLOW NEW YORKERS BY ALLOWING VISITORS TO OUR CITY PARKS AND BEACHES TO BREATHE FREE FROM TOBACCO SMOKE.

AS SOMEONE WHO HAS RESTRICTED LUNG CAPACITY AND ASTHMA, OUTDOOR TOXIC TOBACCO SMOKE IS HARMFUL TO ME AND OFTEN UNAVOIDABLE TRYING TO EARN A LIVING AND FULFILLING EVERYDAY RESPONSIBILITIES. EVIDENCE OF THE HARMFUL EFFECTS OF OUTDOOR ETS WAS CONFIRMED IN 2006 WHEN BOTH THE U.S. SURGEON GENERAL'S REPORT CLEARLY STATED THAT THERE IS NO SAFE LEVEL OF EXPOSURE TO SECONDHAND SMOKE AND THE CALIFORNIA EPA DECLARED OUTDOOR TOBACCO SMOKE AS A "TOXIC AIR POLLUTANT."

HOWEVER, I HOPE AND LOOK FORWARD TO THE DAY OF BEING ABLE TO RELAX IN A SMOKEFREE LOCAL PARK. IF 470 MUNICPALITIES IN THIS COUNTRY HAVE ALREADY PASSED SMOKEFREE PARK LEGISLATION, LET ME REPEAT THAT, 470 MUNICAPALITIES HAVE SMOKEFREE PARKS INCLUDING SAN FRANCISCO, LOS ANGELES, SAN DIEGO AND ALBUQUERQUE AND THE ENTIRE COMMENWEALTH OF PUERTO RICO, THEN WHY SHOULDN'T THE GREATEST CITY IN WORLD BECOME #471? YOU AND THE FULL COUNCIL HAVE THE POWER TO DO THAT AND I AM ASKING YOU TO SIEZE THIS OPPORTUNITY AND SET THE EXAMPLE FOR ALBANY TO FOLLOW.

I WOULD ENCOURAGE THE HEALTH COMMITTEE TO STAND TALL AND STRONG AND NOT FALL TO THE LOBBYING ONSLAUGHT THAT YOU WILL BE SUBJECTED TO IN THE COMING MONTHS AS INTRO 322 WORKS ITS WAY THROUGH THE PROCESS.

AS A VETERAN OF SMOKEFREE ADVOCACY TESTIMONY SINCE THE EARLY 1990'S I'VE SEEN WHAT PRESSURE IS PUT AGAINST PAST COUNCIL MEMBERS BUT I AM CONFIDENT THAT THE HEALTH COMMITTEE AND EVENTUALY THE FULL COUNCIL WILL PASS THE STRONGEST POSSIBLE BILL WITHOUT ALLOWING ANY AMENDMENTS TO WEAKEN INTRO 322 BEFORE MAYOR BLOOMBERG SIGNS THE BILL INTO LAW.

IN THAT VAIN, I URGE THE HEALTH COMMITTEE TO VOTE DOWN INTRO 381 THAT WAS JUST INTRODUCED BY CM PETER VALLONE JR. TO ALLOW SMOKING SECTIONS IN PARKS. HOW IRONIC IS IT TO HAVE THE VALLONE NAME NOW ASSOCIATED WITH A WATERDOWNED SMOKEFREE AIR LAW WHEN THE VALLONE NAME WAS THE CITY COUNCIL'S STRONGEST ADVOCATE OF NYC'S CLEAN INDOOR AIR ACT IN THE 1990'S.

PHIL KONIGSBERG
BAY TERRACE, NY

October 14, 2010

Good Afternoon,

My name is Beverly Nelson and I am the proud mother of Michael, who is 6 years old. Unfortunately he suffers from Asthma. I take precaution in every way imaginable to prevent him from having an asthma attack; however, there is one trigger that I cannot control and it is second hand smoke. It only takes a matter of minutes of exposure to second hand smoke to cause him to have a full blown asthma attack. No parent wants to see their child suffer an asthma attack. It is one of the most devastating experiences to go through, especially when it's due to other's negligence that you cannot protect your child from. I cannot stop others from smoking around my child at the outdoor recreational places. I can, however, confine him at home so that he will not be exposed to toxins that are caused by second hand smoke which trigger his asthma.

I have to live with making the decision between either letting him go outside to enjoy his childhood or to keep him confined and unhappy so that he remains healthy. This is an unfair decision for parents with children who suffer from asthma have to make every single day. Therefore, I support a Smoke Free Public Policy at places such as: NYC Parks, Plazas, Beaches, and other outdoor Recreational Places. I think our children deserve to come out and play and remain healthy while doing so.

Thank you,

Beverly Nelson

Beverly Nelson

Leonard Waller
3021 Briggs Avenue
Apt. # ST-1
Bronx, NY 10458-1633
(347)-297-8501
smdad@optonline.net

Oct. 1, 2010

Joe Mancino
New York City Council
250 Broadway,
New York, NY 10007
Council's Human Services Division

The honorable Mayor Bloomberg, & all members of the New York City Council,

I request the opportunity to express my thoughts & views on Intro. 332, legislation introduced by Council Member Gale Brewer and in conjunction with Mayor Bloomberg, that would prohibit smoking in pedestrian plazas and public parks. I am totally opposed to the ban.

1) "Smokers are not piranhas on society" I am a 60 year old New Yorker, father & grandfather & tax-paying citizen.

1A) The City Parks, Plazas beaches are for everyone, Smokers, Non Smokers, Citizens, & tourists. As to the smell, of "Smoke in the air. The air belongs to everyone & no-one. We smell car exhaust, we smell cooking exhaust from restaurants. We smell the grills burning from Street Vendors. If we go to the parks we smell the smoke from BBQ & picnics. Many of the city's historic & beautiful buildings & Brown Stones have working Fireplaces, that emit smoke.

1B) As to the litter smokers create. We already have laws in place enforcing littering.

1C) As to smoke from tobacco being an offensive odor. I might be sitting next to someone in a park or city plaza & their food has an offensive odor to me. Are we going to ban eating in parks & plazas? What if their cologne or Perfume is overwhelming, do we ban it's use in Parks, beaches, & plazas?

2) Cigar & pipe smokers look to see, smell & feel the product of their desire, & choice. Thus many Cigar shops have either walk in humidors. Or the entire shop is humidified & temperature controlled, & the Cigars & tobaccos are available so choose from.

3) As for the decline of smokers since the Tax increase, the number is not true. Many smokers went to other states, the Internet, & Black Market. Thus the decline in the number of Tax Stamps Sold, & the loss of Tax Revenue to the City, State, & Federal Government.

4) Mayor Bloomberg has stated he doesn't care about the loss of revenue from smokers. It will be made up elsewhere. Most likely in higher taxes for everyone.

5) My objection to the outdoor smoking ban proposal. If I am walking by a park. If I am next to the entrance or the railings, walls, of the park. I might be considered as to smoking in the park. On Central Park West, & South benches go around the outer perimeter of the park. So if I stand next to an outer bench or sit on it. I could be ticketed for smoking in a park. If I am driving an open car through a park or on a park drive is that smoking in the park?

6) I address the issue of increase of Teens smoking cigars. Those inexpensive cigars, "Blunts" El Producto, White Owl or Black & Mild, are cut open & filled with Pot or coke & Pot.. Their cost is usually a dollar or less.

7) Cigar smokers, who purchase quality cigars at licensed Tobacconists & Cigar Stores, spend an average of $5 to $10 a cigar.

7A) These small shops pay rent, buy products, employ people, pay commercial rent tax, collect sales tax, and provide the city with a traditional industry.

8) Raising of the age to purchase Tobacco products to 19. At 18 a citizen can enlist in the Armed Forces. They can make a conscious decision to serve their country. To protect all it's laws & citizens. At any cost. Including the loss of their life.

But the State of New York wants to say they can make a decision to serve their Country. But they can't make a decision as to smoke, or purchase tobacco products.

9) The perception that all smokers are addicted to Nicotine is not true!

Many of us enjoy a Cigar, Pipe, or cigarette, at the end of our day. Some while exercising their pets in the park. It is their personal & quiet time. Some enjoy smoking after a good meal. Although it has become much harder in NYC. since 2003.

I would welcome to opportunity to help in forming any changes to the existing smoking laws. The law must protect us all, smokers, & non-smokers.

Respectfully yours,

Leonard Waller

Barbara Fischer Public Hearing (NYC Council) 10/14/10 10/13/10

As a proud member of NYC CLASH, I plan on attending the above hearing to oppose this additional ban on smoking in public spaces. ENOUGH IS ENOUGH ALREADY! Our legislators at all levels should stick to righting the many bloated, abusive, and inefficient monstrosities they've created over the years like the MTA, the Water Board, and the Port Authority, just to name a few. How about reviewing the civil service systems where pensions, benefits, and multiple-dipping are out of control? Governmental entitlements of all kinds should be reviewed and reigned in.

But in the current Kafka-esque nightmare of bureaucracy and economic depression, do our elected officials try to ameliorate, much less address these problems? No, they prefer to pander to the already-entitled special interest groups by creating additional "nanny" laws which serve only to further harass and hinder the working and small business classes. COMMON SENSE QUESTIONS! This proposal started out because of litter on beaches. First, are smokers the only ones littering? Second, where are all the public ashtrays? (Wouldn't a tossed butt into a litter basket ignite a fire?) Third, since the books already have litter laws, why aren't they being enforced by all the agents of EPA, DEP, sanitation, etc? Cite all those who litter including smokers and earn your civil service salaries.

King Bomberg has made our city a showplace and magnet for the elite, entitled, and tourists. The "Pedestrian Malls," bike lanes, and tree-plantings all appeal to the media and the "Now, Me, I, and My" people (the self-centered and self-promoting individuals and lobbying groups). And to a point, in better economic times, that's okay, but what about Us other folk (the working and small business classes)? - we pay taxes, vote, and obey laws. Our voices are ignored, but we do get saddled with "nanny" laws, sneaky, hidden taxes, outrageous housing costs, and the palaver and pablum of posturing politicians. We get no governmental hand-outs, patronage, or pork, nor can we afford an entourage of attorneys, accountants, and sycophants to insulate us against the realities of NYC living.

And last, but certainly not least, what about our rights? Much like a horde of hyenas attacking a wildebeest, the wolf-pack oligarchs of government and anti-smoking advocacy have targeted and hunted down a scapegoat. In tandem, they have fabricated a smokescreen (pun intended) like the Wizard of Oz. This construct is a diversion serving many purposes: enacts restrictive caretaker legislation while making it appear that something productive is being done, generates income, and isolates and, hopefully from their perspective, eliminates the smoker. The wolf-pack justifies its tactics and goals by citing the "public good" to

deny and restrict our choices, making smokers pariahs in the process. To that end, they use distorted epidemiological studies on second-hand smoke with flimsy, statistically insignificant data. Like all fanatics before them, including Nazis and Stalinists, anti-smoking zealots use any and all means to achieve their ends.

This form of advocacy is unvarnished bullying, and there is a lot of talk these days about overt and covert forms of bullying. Whether it is the schoolyard, cyberspace, or the anti-smoking crusade, silence is the bully's partner in crime, and we will no longer be silent. Even recent polls show that the public, including non-smokers, are not in favor of banning smoking in the open air of public spaces. Get rid of all exhaust from vehicles, furnaces, generating plants, cattle, and the open mouths of do-gooders and politicians, then let's talk.

Can't our elected officials find other ways to justify their existences - like doing their jobs and leaving us alone?

Trffls/Bpth/7-8

Please, do not pass THE PROPOSAL TO BAN OUTDOOR SMOKING IN PARKS, PEDESTRIAN MALLS, and on BEACHES (Intro 332).

I am 42. I was diagnosed with idiopathic hypersomnia, which is essentially narcolepsy without cataplexy, according to someone at Stanford, on 8/23/10 here in NYC. It's a diagnosis in progress. I had a "nervous cough" as a young child and no wind capacity when I was in middle school. By my early 20's, I could barely bring myself to walk around the University of California at Berkeley campus to get to my classes. By 26, my condition became severely debilitating, following a month long bout of what seemed to be the flu. As a smoker, I was disregarded often by doctors. Narcolepsy is not know to affect the lungs but it was my oversleeping that was the recognizable symptom.

For the last 25+ years, my primary substances used to fight my condition has been cigarettes, coffee and sugar. My condition seemed degenerative condition, in my experience. At least, last year it seemed I didn't have the strength to continue.

Within days of medicine for my medical condition, my breathing capacity improved. This week my blood oxygen increased 97% to 98%! I am optimistic that it will rise more.

There remain many people with undiagnosed, untreated medical illness that need something like tobacco to help them get through the day.

Quitting smoking by at least one of my doctors has been quoted "The single best thing you can do for your health." I believe the person meant physical health, not mental health. Smoking has been an invaluable coping mechanism. I am likely to reduce my tobacco consumption as my physical health improves with the medication for my idiopathic hypersomnia.

You may have heard that the schizophrenics experience improvement of reduce psychotic symptoms and impulsivity with nicotine. Issuing smoking licenses to disabled people would be to single us out and only be available to those with a diagnosis of specific medical conditions. One person left out would not be acceptable. Try getting a Disabled Parking Placard in this town. And, what is the person to do while waiting for the medical evaluation. Again, this would not be acceptable.

Tobacco existed on this continent before the arrival of the Europeans. Before the arrival of the Europeans, it is thought by some people that disease did not exist in the Americas. Maybe, that was communicable diseases that didn't exist. I believe tobacco may have been a homeopathic remedy and the combination of the smoke that soothed, along with the nicotine. Tobacco was an intrinsic part of Native religion, too, at the very least, for the Choctaw, a Southern tribe, from what I have read.

An argument might be able to be made for Freedom of Religion, but because of the lack of documentation for many people of native descent and the nature of tobacco, limiting tobacco to Federal land like the Rastafarians for marijuana or requiring Native documentation is not a satisfactory resolution.

As you may know, many Native tribes were annihilated or rounded up into central locations. Yet, tobacco continued to survive and from what I've heard was a fundamental part of this countries economy.

Requiring Native documentation would not be acceptable because many natives can not get

documentation because it never existed or was destroyed by events like fires at the county courthouse.

For me my right to smoke has gone beyond The Pursuit of Happiness but it has been the very thing that has made existence almost bearable. Plus, it is my body. I have the right to do with it as I please. And, soothing my craving for nicotine is one of the right's that I should continue to have. I was once told by a Jesuit that Native American religion does not count because it was not organized. Well, in the Americas, as far as I am concerned, Native American religion does count. Even if the vast majority of Natives have converted from what I can tell, the religious substance did not die out with the religions and in some respects is one of the links to the past remaining, in my opinion.

Without a cigarette, I could not participate in most activities, including going to the beach. I pick up my cigarette butts from the beach. I am guilty of leaving them around town. But, if there were more ashtrays and I was reconditioned my butts would be put where they belong. I am in support of enforcing the litter law on the beach and ashtrays in other places. Also, enforcing the no public urinating law, if we have one, would be nice.

I do not want to deprive anyone of their rights anymore that I want my rights deprived. There are extreme lung conditions for which smoking may be a hazard . However, I am not convinced secondhand smoke is a real issue, otherwise, save the most extreme of cases, perhaps.

There is no solid evidence that tobacco is the sole cause of the lung disease that it's being held responsible for and the cause of all of the deaths to which it is attributed.

I am still on the fence about second hand smoke. What level is an issue and what definitive proof exists for tobacco smoke being a real problem in and of itself? But, as a precautionary measure, I do have a $300+ commercial-grade air purifier with a carbon filter running around the clock where I smoke the most.

Both my father and grandmother died of lung cancer. My father, also, had my oversleeping problem, but I am not sure what was wrong with my grandmother. I know a woman who is 84 who has been smoking at least since her 30's. Most of her life she has had no real health problems. She is starting to now, but it does not seem to be related to smoking. Like my grandmother, she did not drink alcohol. And, I have seen my father die of cancer and what my great-aunt as she was losing her mind following amputations related to diabetes. I would choose a quicker death by cancer over a drawn out death by diabetes where I did not maintain my mental faculties.

The doctors told people for 20 years if you put a baby to sleep on it's stomach it might die. SIDS was found to be a brain stem defect. Yet, the doctors still said to put the babies to sleep on their backs, which was not a complete retraction. The SIDS scare resulted in many sleepless nights for, at least, me, until I came to my senses, coincidentally about a month before the doctors found the actual cause of SIDS.

Doctors have been quick to dismiss me or blame all of my health problems on smoking, when I had a much more serious underlying concerned. Had I quit, they would have blamed my problems on my being an ex-smoker. It took me a long time to find a doctor that was willing to listen.

I am by no means even remotely convinced that minimum or mild smoking will have any impact on the health of a healthy person. I have to look at things that are unpleasant on a regular basis. I smell things

that could make you sick all over the city. Plus, car put out more smoke that cigarettes. A little whiff of something you do not like to smell is not a federal case. In addition, I love the smell of cigarettes usually and it conjures up fond childhood memories for me.

One of the many reason that I left the West Coast was to get away from all of the smoking bans. But, it wasn't long before the bans began here in NYC.

If 25-30% of people are smokers, then we should have 25% of the establishments as smoking establishments with big signs that read "THIS IS A SMOKING ESTABLISHMENT". And, there should be proper air filtration in those establishments like they had at the Oak Club in the West Village in 1998. When I was there and smoking was legal, I was impressed by the fact that there was little secondhand smoke lingering in the air, despite many patrons smoking.

Back in the day, the smoking section of an airplane was the place to be, so being segregated would not be a problem by me.

And, as a smoker, I'm seeing very little representation of my interests. The taxation on cigarettes should be unconstitutional if it's not already. Receipts don't even show the tax or tax percentage. If there was a roughly 200% tax on any product other than tobacco, constituents would most likely become enraged. At one point there were rumors of outdoor smoking rooms that would be built as shelters from the cold for smokers. However, I do not know what happened to that idea. For the taxes on tobacco, I would think that we would have luxurious shelters from the cold. But, apparently, it is good enough for us that we be put out like the dog. Raynaud's Syndrome, sensitivity to the cold, that I have had since at least 15 years of age, makes being outside in the cold very physically painful.

But, pressure from politicians, doctors and the masses of non-smokers has placed an unfounded sense of guilt on smokers. There should be no taxation without representation. As far as the chemicals in cigarettes, little seems to have been accomplished to get the commercial manufacturers to remove them. Calories are now listed in restaurants menus as required by law, yet the ingredients in commercial cigarettes are not printed on the boxes.

I am not encouraging smoking in people that do not already smoke. I would rather them not have the need to smoke and perhaps in some cases receive the medical treatment they need, if necessary. If you smoke as I have, there is a lot of expense and effort around the acquisition of cigarettes that can be an inconvenience, even at legal prices. I was mugged when I went out for a pack of cigarettes tired at 10p.m. in Brooklyn in 2001.

My father and grandmother did not want me to smoke and at 7 gave me a cigarette to cough over. I had no inclination towards smoking. At 13, when some neighborhood kids brought a cigarette and a bottle of ever clear to my house, I had never heard that there were any health concerns. We all drank one sip of ever clear and shared the cigarette. As I got older, I had heard tobacco was addictive, but I thought only weak people became addicts. It took me years of smoking sporadically from ages 15 to 17 to develop an actual addition. I did not make a knowingly unhealthy choice.

A side note is that to reduce fires, anholt ashtrays, whose shape I can't quite describe well as somewhat pear-shaped, should be the mandatory or highly recommended ashtray.

I am asking for compassion from the majority for a minority group. Is it acceptable to harass smokers in

the street? Strangers on the street make direct and indirect comments about my smoking, while others feign a cough or wave there hands in front of their noses when no where near smoke, yet. And, if I raised my hand in protest, how would I be viewed? But, I feel that non-smokers are literally trying to provoke me on the street. And, other non-smokers have observed the unprovoked, non-smoker aggression towards me. How is it morally conscionable to stand by and watch me suffer while I am compelled to stop my withdrawals with a cigarette, when the substitutes available in the U.S. are not satisfactory. In other countries, nicotine inhalers can be acquired.

I have heard nicotine is more addictive than heroine. Having never been a heroine addict, I have no point of reference, but I would be willing to accept that opinion. But, I can say I have been around a bit. And, nicotine is the only addiction with which I walked away. I have quit smoking three times in my younger years for six months only to return to smoking due to stress. I might be a very rude person violating other people's rights by taking out my frustrations at every turn if I did not smoke.

When Society is healthy financially, spiritually, mentally and financially there will be no need for drugs, including tobacco.

I need the Right not to Suffer Physically. And, The Right to Liberty and The Right to Have a Life are rights that I should not be denied.

Also I'm asking maybe a little prematurely that tobacco smokers do not support ANY pro-marijuana legislature if we do not make any progress with tobacco. Tobacco can be smoked in a similar style to marijuana. But, both tobacco and marijuana produce smoke. Tobacco is legal and does not get you high. I am seeing a general lack for support for tobacco by marijuana smokers. I will not even consider supporting marijuana, if I know there is a lack of support for my cause.

Written By: Margaret Michele Waldman, a smoker
Edited By: Richard Allen Morales, a non-smoker

FOR THE RECORD

GASP

7 Cedar St., Suite A
Summit, NJ 07901
Phone: 908-273-9368
Fax: 908-273-9222
Email: info@njgasp.org
www.njgasp.org

October 8, 2010

Smokefree Outdoor Recreational Areas

There is growing concern that outdoor secondhand smoke (SHS) can pose a health hazard to both people and the environment. Recent studies show that outdoor exposure to concentration levels of SHS can exceed current U.S. EPA limits on fine particulate matter pollution. Children are particularly susceptible to SHS exposure. Even brief exposure to SHS can trigger serious health problems for asthmatics, and people with compromised cardiovascular systems.

There is a compelling basis to institute smoking bans to protect individuals in outdoor settings, and more than 100 local NJ governments have shown support for smokefree air outdoors by enacting more than a hundred ordinances to protect health, control litter, reduce fires, guard infants and animals from ingesting poisonous tobacco butt waste, and reduce environmental toxicity. In fact, 84% of adults in New Jersey are nonsmokers and 70% of smokers want to quit.

Outdoor bans help:

- Protect people, especially children who congregate at parks, playgrounds and beaches, from secondhand smoke. Studies show that concentrations of outdoor SHS can equal indoor SHS levels.
- Set a standard that promotes public health by creating healthful environments for outdoor exercise and activities, and helps to normalize smokefree environments.
- Promote community efforts to "go green" and be environmentally friendly.
- Eliminate the concern of discarded cigarette butts that are ingested by children and animals.
- Improve oceanic and marine life with lower toxicity levels by reduced butt waste in lakes, bays and oceans.
- Reduce litter and the increased costs for municipal county and state clean-up costs for recreational areas.
- Reduce accidental fires caused by discarded cigarette butts in forests and parks.
- Facilitate the preservation of land and water for conservation and recreational purposes.

The following information outlines the trend with supporting data to create 100% smokefree policies for parks, playgrounds, recreational areas, athletic fields, swimming pools, and beaches.

1. New Jersey state, county and local legislation, regulations, and policies show support for smokefree outdoor environments from many departments and levels of government:

2006 New Jersey Smoke-Free Air Act (NJSFAA) prohibits smoking outdoors:

- on all public and private K-12 school grounds, NJAC 8:6-7.1 and 2.
- at an exterior area if smoking in the exterior area results in migration, seepage, or recirculation of smoke to an indoor public place or a workplace at which smoking is prohibited, NJAC 8:6-2.3 (a) and (b).

Resource Family Homes (foster homes, adoptive homes, family friend homes and relative care homes): this New Jersey regulation bans smoking in all resource family homes, cars that transport a resource family child, and outdoors when a resource family child is present. N.J.A.C. 10:122C-7.2(a)(3) was adopted by the Department of Human Services on December 19, 2005, effective February 6, 2006 (from the Manual of Requirements for Resource Family Parents at http://www.state.nj.us/dcf/divisions/licensing/RFmanual.pdf)

Any public place: smoking or carrying lighted tobacco may be prohibited by the owner or person responsible for operating any public place or by municipal ordinance under the authority of NJSA 40:48-1 and 2. Conspicuous posting of adequate notice of the prohibition is required. This law may also apply to outdoor area, including sports facilities. NJSA 2C:33-13(b)

Policies:

- The Meadowlands Sports Complex is 100% smokefree, as are other professional athletic stadiums' seating areas.
- Raritan Valley, Bergen, Camden and Morris County colleges have 100% smokefree campuses, and Gloucester County College effective 9/1/10; Middlesex County, Brookdale Community, and Sussex County colleges have smoking-restricted campuses; Ocean County is 100% smokefree, except for parking lots. Ramapo College prohibits smoking 25 feet from the entrance to any campus building.
- Hospital campuses: there are more than 90 tobacco-free hospital campuses in NJ.

There are 109 municipalities and 8 counties that passed 136 outdoor bans that eliminate or restrict smoking near government buildings, in parks, playgrounds, recreational fields, swimming pools, and beaches. Within those ordinances, the following specifically regulate:

- 2 counties and 88 municipalities have passed 100 ordinances to ban the use and discard of tobacco products in parks and recreation areas.
- 18 municipalities regulate smoking at ocean, bay, and lake beaches. Belmar was one of the first in the country to limit smoking on the beach and the boardwalk. The first summer after the ordinance was enacted, beach tag revenues increased by 17.6%. http://www.njgasp.org/Belmar_beach_ordinance_sf_effects_article.pdf
- 13 municipalities and Bergen and Union Counties have banned smoking at swimming pools.
- 5 counties and 18 municipalities have established outdoor perimeters around or near government-owned facilities. Setbacks range from 10 feet to 50 feet from entrances and/or perimeters of buildings and some have all grounds smokefree.
- 2 counties and 1 municipality have banned smoking at zoos to protect the patrons, especially the children, and the well being and safety of the animals as well as potential damage to surrounding vegetation: Turtle Back Zoo, Essex County, Cape May County Zoo, and Cohanzick Zoo, Bridgeton.
- Six Flags Amusement Park was made smokefree by an ordinance prohibiting smoking on the premises of any amusement part located in the Township of Jackson.

Search GASP's New Jersey local laws database at http://njgasp.org/d_search1.asp.

2. Legislation outside of New Jersey:

On September 15, 2010, New York City proposed an ordinance to mandate 100% smokefree city parks. This includes all public parks, beaches, boardwalks, golf courses and pedestrian plazas under the auspices of the NYC parks department.
http://njgasp.org/NYC_outdoor_parks_ban_Sept-2010.pdf

U.S. states, municipalities, and commonwealth territories have passed 100% smokefree legislation. *

- 100 municipalities (includes 10 in NJ) prohibit 100% smoking on beaches.
- Maine prohibits smoking State beaches and the Commonwealth of Puerto Rico bans smoking on beaches.
- 192 municipalities and the States of Iowa and Wisconsin, the Territory of Guam, and the U.S. Virgin Islands prohibit 100% smoking in outdoor public transit waiting areas.
- 177 Municipalities and the States of Hawaii, Iowa, Maine, and Washington, and the Commonwealth of Puerto Rico have enacted laws for 100% smokefree outdoor dining areas.
- 470 Municipalities (includes NJ) and the Commonwealth of Puerto Rico prohibit 100% smoking in all parks.
- 46 Municipalities (includes NJ) and the State of Oklahoma prohibits 100% smoking in all indoor and outdoor areas of zoos.

* These lists can be found at http://no-smoke.org/goingsmokefree.php?id=519#outdoor.

3. Studies that show measurable harmful effects from secondhand smoke exposure outdoors:

Outdoor SHS is determined by the density of smokers, the wind velocity (direction and speed), and the stability of the atmosphere. During continuous smoking, SHS levels outdoors may be as high as SHS indoors.

- 2010 study of children exposed to secondhand smoke between ages 8 to 13 are more likely to show thickening of blood vessel walls, a precursor to hardening and clogging of arteries.

Children exposed to the most SHS had higher levels of apolipoprotein B, which contributes to "bad" cholesterol, another heart disease risk factor. The findings suggest that children should not be exposed to SHS at any level; even small amounts of SHS exposure may be harmful for blood vessels. The researchers concluded that children need to be provided with a smokefree environment.

Circulation: Cardiovascular Quality and Outcomes, A Journal published by the American Heart Association, March 2010. http://www.njgasp.org/Kallio_2009_study-SHS_increasing_risk_of_childhood_arterial_blockage.pdf

- 2009 study to SHS exposure at outdoor bars and family restaurants in Athens, Georgia, using salivary cotinine. Conclusion: Nonsmokers outside restaurants and bars in Athens, Georgia, had significantly elevated salivary cotinine levels indicative of secondhand smoke exposure.

  The objective of this study was to measure salivary cotinine, a metabolic byproduct of nicotine, in 21-30 year olds exposed to SHS outside bars and restaurants in Athens, Georgia. The study, one of the first to assess levels of cotinine in nonsmokers exposed to SHS outdoors, found levels up to 162% greater than in the control group that was not exposed to outdoor SHS. The results were published in the Journal of Occupational and Environmental Hygiene.

  The team found an average increase in cotinine of 162% for the volunteers stationed at outdoor seating and standing areas at bars, 102% for those outside of restaurants, and 16% for the control group near the library. Cotinine levels in the volunteers at the bar setting saw their levels increase from an average pre-exposure level of 0.069 nanograms per milliliter (ng/ml), to an average post-exposure level of 0.182 ng/ml. The maximum value observed, however, was 0.959 ng/ml. To put that number into context, a widely cited study has determined that an average cotinine level of 0.4 ng/ml increases lung cancer deaths by 1 for every 1,000 people and increases heart disease deaths by 1 for every 100 people.

  The University of Georgia, College of Public Health, Department of Environmental Health Sciences, Athens, Georgia, Hall JC, Bernert JT, Hall DB, St. Helen G., Kudon LH, Naeher LP http://oeh.informaworld.com/soeh/content~content=a914966130~db=all~jumptype=rss

- 2007 Stanford University Study on real-time measurement of outdoor tobacco smoke particles. Measured SHS respirable particle concentrations in outdoor patios, on airport and city sidewalks, and in parks. Concluded within about 2 feet of a smoker outdoor SHS was quite high and comparable to SHS concentrations measured indoors, and levels measured at two sidewalk cafés were detectable at distances beyond 13 feet. Researchers surmise:

  1. Children who accompany a smoking parent or guardian may experience substantial exposure.

  2. Support for health-based outdoor SHS bans may lie in a potential acute effect on susceptible populations. Short-term OTS exposure might be life threatening for high-risk persons, since the human cardiovascular system is very sensitive to secondhand smoke.

  Klepis, Ott, and Switzer, http://news-service.stanford.edu/pr/2007/pr-smoke-50907.html

- 2008 Fact Sheet on outdoor air pollution from SHS by researcher James Repace: Field studies and controlled experiments demonstrate that, regardless of which way the wind blows, an individual in an outdoor cafe, transiting through a building doorway, or otherwise surrounded by a group of smokers, is always downwind from the source. Under some conditions, levels of outdoor SHS can be as high as indoor levels of secondhand smoke (SHS). Some studies and conclusions cited in the fact sheet: **

  1. California: The Air Resources Board study (CARB, 2006), measured SHS nicotine concentrations outside an airport, college, government center, office complex, and amusement park. CARB found that at these typical outdoor locations, Californians may be exposed to SHS levels as high as indoor SHS concentrations.

  2. In August 2003, researchers measured outdoor SHS respirable particle pollution in five outdoor cafes and on city streets in downtown Helsinki. Results found that air pollution

levels in Helsinki outdoor cafes with many smokers during August 2003 were 5 to 20 times higher than on the sidewalks of busy streets polluted by bus, truck, and auto traffic. The results were presented by researchers at the 2006 World Conference on Tobacco or Health in Helsinki, Finland. **

3. In 2005 researchers in Maryland measured outdoor fine particle and carcinogen concentrations from outdoor SHS on the University of Maryland Baltimore campus. SHS levels approached background levels either for fine particles or carcinogens until about 23 feet from the source. **

4. Caribbean: Experiments conducted on a cruise ship traveling at 20 knots at sea in the Caribbean showed that SHS levels in various smoking-permitted outdoor areas of the ship tripled the level of carcinogens to which nonsmokers were exposed relative to indoor and outdoor areas in which smoking did not occur, despite the strong breezes and unlimited dispersion volume. Moreover, outdoor smoking areas were contaminated with SHS to nearly the same extent as a popular casino on board in which smoking was permitted. **

** James L. Repace, MSc., Visiting Assistant Professor, Tufts University School of Medicine, and Repace Associates, Inc., 101 Felicia Lane, Bowie, MD 20720 U.S.A., http://www.repace.com/pdf/OTS_FACT_SHEET.pdf

- 2009 Australia study SHS exposure (PM2.5) in outdoor dining areas. Conclusions: When individuals sit in outdoor dining venues where smokers are present, it is possible that they will be exposed to substantial SHS levels. Significant increases in exposure were observed when monitors were located under overhead covers, and as the number of nearby smokers increased. The role of outdoor smoking restrictions in minimizing exposure to SHS must be considered. Cameron M, Brennan E, Durkin SJ, Borland R, Travers MJ, Hyland A, Wakefield MA, Cancer Council Victoria , Australia, *Tobacco Control* 2009 Oct. 21. http://tobaccocontrol.bmj.com/content/early/2009/10/21/tc.2009.030544.abstract

4. Environmental hazards and litter:

Discarding cigarette butts can start fires that may destroy a forest, park, field, and people's homes.

Every year 4.95 trillion cigarette filters are discarded globally into our environment and many are found on sidewalks, beaches, parks, and other public places and often end up in our waterways and washed back onto beaches. Cigarette filters can take many years to decompose but they are not 100% biodegradable. As filters break down, they leach toxic chemicals into watersheds, streams, lakes, and oceans, and are hazardous and highly toxic to fish, birds, other wildlife, plus pets and young children if they are ingested. Carried as runoff from streets to drains, to rivers, and ultimately to the ocean and its beaches, cigarette filters are the single most collect item each year in international beach cleanups. http://www.cigwaste.org

Alliance for a Living Ocean conducted a Long Beach Island, NJ beach clean-up, for its 17th annual Earth Day Clean-up on April 24, 2010. The most common trash item were cigarette butts. Cigarette lighters, cigar tips and tobacco packaging/wrappers were also collected. http://www.livingocean.org/assets/earthday2010_cleanup.pdf

The 2008 Annual Report of the Clean Ocean Action, a coalition of 125 organizations working to improve and protect the waters off the New Jersey and New York coasts, states that cigarette butts were the single most recovered item during beach sweeps in 2006, 2007, and 2008. 41,900 Cigarette filters were recovered in 2008 during Spring and Fall sweeps. Floating cigarette filters mimic fish, and filters have been found in the stomachs of birds and larger fish, blocking and affecting their digestion. Also, the filters are made of plastic fibers and trap carcinogenic chemicals that are introduced into animals' bloodstreams. http://www.cleanoceanaction.org

NJ REBEL Clean-ups

NJ REBEL is a statewide, youth-led tobacco-free movement, dedicated to educating peers, middle and elementary school children, and other members of the community about the dangers of tobacco use. NJ REBEL (www.njrebel.com) operated under the auspices of the New Jersey Department of Health and Senior Services' Comprehensive Tobacco Control Program. On August 20, 2001, more than 700 NJ REBEL teens conducted a statewide beach sweep, cleaning litter from eight New Jersey beaches,

and collected 38,000 cigarette butts in just 2 1/2 hours. County-wide NJ REBEL groups also conducted 2009 outdoor tobacco litter clean-ups:

- Atlantic County REBEL has conducted cleanups at beaches and parks: two were in Atlantic City and one in Ventnor. The students picked up more than 3000 butts. The previous summer several cleanups were conducted and picked up more than 7,000 butts.
- Bergen County REBEL Clean-ups: 2,000 butts cleaned up by 16 REBEL students at Garden State Plaza. School Clean-ups: 8,000 plus butts cleaned up at 10 high schools and 5 middle schools in Bergen County.
- Camden County REBEL conducted a cleanup in Cooper River Park, Pennsauken. About 20 members from Camden Catholic High School, Cherry Hill, collected cigarette butts that filled a large jug.
- Hunterdon County REBEL, 50 students cleaned up their school campuses at Delaware Valley, North Hunterdon and Central, and Latino REBEL cleaned up The Flemington Arms Apartment complex, collecting 1,083 cigarette butts in June.
- Mercer County REBEL, 150 volunteers collected about 500 cigarette butts in a school grounds cleanup in June.
- Somerset County REBEL collected 2,500 cigarette butts.
- Warren County REBEL conducted on beach cleanup in June at Point Pleasant Beach with three high school chapters participating. They found about 3,000 cigarette butts along a small stretch of coast.

5. "Go Green" trend supports outdoor smokefree environments:

Outdoor smokefree recreational environments align with community efforts to promote "going green". Environmentally-friendly plans should incorporate clean air and reduced litter, which decreases a community's carbon footprint.

- TripAdvisor's 2010 annual beach and pool etiquette survey of more than 2,000 U.S. travelers found that 83 percent believe smoking should be banned around the pool, while 64 percent maintain that it should be disallowed at the beach. Their 2009 survey of more than 3,000 travelers ranked smoking as the second most annoying beach and pool etiquette violations.

Outdoor smokefree beaches and pools may cast a positive influence on travelers' destination decisions, and travelers are choosing environmentally-friendly hotels:

- TripAdvisor's 2009 annual travel trends survey also found that thirty-four percent of U.S. respondents said they will visit an environmentally-friendly hotel or resort in the coming year, up from 30 percent in 2008. Thirty-two percent of those surveyed said they will be more environmentally conscious in their travel decisions this year, than they were the year before. In July 2008, only 26 percent said they would be more environmentally conscious.

6. Normalization of outdoor smokefree environments:

The Center for Disease Control and Prevention (CDC) states that smokefree policies reduce smoking among all ages. By challenging the perception of smoking as a normal adult behavior, smokefree policies can change the attitudes and behaviors of adolescents, resulting in a reduction in tobacco use initiation (Oxford University Press, October 2006). The study "Association Between Household and Workplace Smoking Restrictions and Adolescent Smoking" published in the *Journal of the American Medical Association* in October 2006, found that adolescents who work in smokefree workplaces are significantly less likely to be smokers than adolescents who work in workplaces with partial smoking restrictions.
http://jama.ama-assn.org/cgi/content/abstract/284/6/717

Many high-profile athletes, coaches, agencies, and organizations joined CDC's tobacco-free sports movement which includes agencies and organizations that support tobacco-free sports. Participants include CDC, World Health Organization, National Cancer Institute, National Clearinghouse for Alcohol and Drug Information, National SAFE KIDS Campaign, International Olympic Committee, Federation Internationale de Football Association, and many other sports leagues and youth organizations.
http://www.cdc.gov/tobacco/youth/sports/index.htm

Minnesota's tobacco-Free Youth Recreation program began in 2000, and since that time has assisted more than 90 Minnesota cities and four counties in establishing tobacco-free policies for their parks beaches, athletic fields, playgrounds, and other recreational facilities.

http://www.ansrmn.org/programs/tobacco-free-youth-recreation

7. Lawsuit pending in trial court:

In 2009, the California Court of Appeals allowed a family with a 5-year old to proceed to trial on their complaint against their landlord, based on their cause of action that outdoor smoking created a nuisance, in the outdoor common areas of their apartment building.

This ruling is precedent-setting, in that it addresses "outdoor" SHS may constitute a nuisance, and can be applied to other outdoor settings in multi-unit housing complexes, such as balconies, patios, etc. Landlords and condo associations may want to consider banning or restricting smoking in common areas, to limit potential legal liability in any future nuisance lawsuit concerning outdoor smoking.

TESTIMONY IN SUPPORT OF INTRO 332 - SMOKE FREE PUBLIC PARKS, BEACHES & PEDESTRIAN PLAZAS

Good Afternoon. My name is James Pistilli. I am a Staten Islander testifying in support of Intro 332. Through my positions in a number of civic groups and community-based organizations, including Chairperson of SIQuit's; President ,Tottenville/ Charleston Civic Association; Chairman Conference House Park Conservancy and Board member Conference House Association I have firsthand experience of tobacco's detrimental effects on the health, environment, and overall wellbeing of our Island and its people.

Tobacco smoke is currently the leading cause of preventable death in New York City. Furthermore, the smoking rate in Staten Island is *alarmingly* high - in fact, the highest of all five boroughs. It's no small surprise, then, that our cigarette epidemic also means that we have the highest incidence of cancer, with lung cancer deaths contributing more than any others.

According to the U.S. Surgeon General, there is no safe level of secondhand smoke, both in and outdoors. As a direct result of second-hand smoke, 60% of even non-smoking New Yorkers have elevated levels of cotinine - a byproduct of tobacco smoke inhalation - in their blood. The dangers of second-hand smoke are no longer a matter for debate and discussion - they are a matter of **fact**.

Even worse, exposure to secondhand smoke is greatest among children due to their smaller lung capacity. As a result, secondhand smoke leads to a 50% greater impact on the health of young children. The young - too helpless to even object - are therefore the *number one victims* of secondhand smoke. Yet even today, we *still* lack a policy to suspend public smoking.

Given these basic facts, it is absolutely imperative that our legislators establish policy to protect all citizens - and especially our - children from the harmful effects of public tobacco consumption.

In the summer of 2009, SIQuits with the NYC Coalition for a Smoke-Free City, the American Cancer Society, City of NY Parks and Recreation, and Assemblyman Lou Tobacco initiated a pilot smoking-ban across Staten Island's parks. This coalition developed and promoted our primary theme: "Smoke Free Parks Are Healthy Parks; and Healthy Parks Equal Healthy Kids". The public continues to support this unofficial ban and many have noted that public smoking habits have been significantly lowered, ***especially*** around children. In fact, research indicates that 65% of New Yorkers support a smoking ban in outdoor recreational places like parks, sport fields, and playgrounds.

Our parks and beaches are family gathering places - public sites that are intended for relaxation, recreation and physical activity, *especially* for children and young adults. The presence of smokers secondhand smoke and the litter present from cigarette butts contradict these principles by creating an unhealthy and unwelcoming environment. To be confronted by smoking and secondhand smoke defeats our efforts to promote healthfulness, positivity and good decision-making skills to our youth - it gives the wrong message. Tobacco consumption is an unacceptable behavior in every circumstance, but for us adults to continue to turn a blind eye towards the problem of public smoking is more than unacceptable - it is irresponsible, careless ,and entirely inconsistent with the values we hope to pass along to our children. We must ensure that this is no longer the case.

Dear Legislators,

I came here today to represent the Korean Community and the company, Korean Community Services. It is the largest Korean non-profit organization in the northeast, serving 20,000 clients yearly for over 37 years. New York tri-state has over 200,000 Koreans.

I am in charge of a few youth volunteers and I can recall many instances where we go over to the parks in New York City and we were greeted by cigarette butts. Not to mention passerby who casually smokes and puffs away in our face.

To say the least, this situation should not continue, everyone has a right to breathe fresh air. If we cannot do this at parks and beaches, where can we? I support the 100% ban on smoking at NYC parks and beaches.

Theodore Ryo
Coordinator
Korean Community Services

the Center the Lesbian, Gay, Bisexual & Transgender Community Center

Thursday October 14, 2010:
New York City Council Health Committee
New York City Council Hearing Room
250 Broadway, 14th Floor
New York, NY 10007
Regarding Intro 322-2010

Introduction

My name is Wayne Graves. I am a 62 year old, multi-racial gay male. I'm here to talk to you about the addiction that took away my very breath and why it means so much to me to have smoke free parks and beaches in NYC.
I started smoking cigarettes at the age of 24. By the time I was 50 I had been smoking for 26 years and had never thought about quitting. My cigarettes, ahh, the love of my life-I shall always have you. My friend, lover and constant companion—or so I thought.

My personal challenges with smoking

Until one morning I woke up at 2am unable to breath. I kept gasping for air as if I were being suffocated. My roommate woke up from the sound of me gasping for air and called 911. I was hospitalized for 7 days with an IV of antibiotics in my arm as well as an oxygen mask on my face. I was told to stop smoking immediately. I had no idea that the substance I was inhaling was accumulating in my lungs. I did stop smoking for a few days but was unable to stay quit. That was the first of many visits to the hospital for my cigarette addiction.

A few years later still smoking I was diagnosed with cancer. My radiation treatment lasted for 6 weeks. Well, you would think that would have sent my cigarettes flying into the garbage can, but it didn't. My smoking increased and my excuse was that it eased the pain of the radiation.

When I was 59 yrs old I had a serious case of PCP pneumonia and spent 9 days in the hospital. The doctor told me I would not be able to work anymore and would most likely never work again. I had to file for Social Security Disability with a diagnosis of C.O.P.D. (chronic obstructive pulmonary disease). At that time I managed to not smoke for 1 year.

One year later, late in the evening, the chest pains caught me by surprise. I was working at the computer when I began to be aware of a slight discomfort in my chest. I thought if I just sit and wait it would go away. It did not so I decided to lie down, but still the chest pain persisted. I called 911, it turned out I was having a heart attack. Four arteries had clogged and I had to have a "Stents Procedure" on all four of them. After I was discharged from the hospital I started smoking again because I was feeling so much better. I had no more chest pains and besides, quitting proved to be way too difficult. Six months later breathing became so difficult that my primary care physician sent me back to the Pulmonary Specialist who prescribed in home oxygen therapy. I did not tell either of them that I was still smoking. After having 5 months of oxygen therapy I confessed to my doctor that I was still smoking and she ordered the oxygen tanks be removed from my apartment.

How the Lesbian, Gay, Bisexual & Transgender Community Center helped me

I wanted to stop smoking. I would get 2 or 3 days and sometimes as much as 4days but I always went back. It just seemed to ease the depression. I was killing myself with cigarettes and did not know why--more importantly, I felt I could not stop. In December 2009 I needed help and remembered that The Lesbian, Gay, Bisexual & Transgender Community Center had a "quit smoking program," so I called and found out they were forming a group in January 2010. At last, this was my opportunity to quit. The Center's "Not Quite Ready to Quit" workshop was an eye opener and I was finally able to understand cigarette smoking as a serious addiction. The "Commit to Quit" group helped me to actually quit smoking.

My last cigarette was February 8, 2010 at 8:06 pm. 6 months later my doctor approved me to go back on "in home oxygen therapy" and I can breathe so much better. If I accomplish nothing else in this life--at least I have stopped smoking."

Protect health
Here are just a few facts that are important to me…

- Tobacco **kills** more New Yorkers each year than **AIDS, drugs, homicide and suicide combined.**[1] Every year, cigarettes kill some 7,500 New Yorkers and thousands more suffer smoking-related strokes, heart attacks, lung diseases and cancers.[2]
- There is **no safe level of secondhand smoke exposure.** Just 30 minutes of exposure to SHS can increase risk of

1 Department of Health and Mental Hygiene, "Summary of Vital Statistics 2008". Bureau of Vital Statistics 2008.

2 Summary of Vital Statistics 2008. NYC DOHMH. http://www.nyc.gov/vitalstats.

blood clots[3] and can lead to more frequent asthma attacks in asthmatic children.[4]

- Even with non-smoking policies in place, more than half of non-smoking New Yorkers still (57%) have elevated levels of cotinine, a by-product of nicotine in their blood. This is a result of being recently exposed to toxic secondhand smoke in concentrations high enough to leave residues in the body.[5]
- A person near an outdoor smoker could inhale up to 50 times more toxic material than is found in normal background air pollution.[6]
- And finally, smoking is also a problem for my community – lesbian, gay, bisexual and transgender people. Smoking kills more LGBT people each year than hate crimes, suicide, and AIDS combined, and more lesbians die of lung cancer than breast cancer. 59% of self-identified LBGT teenagers report using tobacco, compared to 35% of self-identified straight teens (CDC Youth Risk Behavior Survey, 2003). And finally, recent studies in New York State found that 70% of people living with HIV are smokers (Burkhalter et al., 2005)

Conclusion

I support Mayor Bloomberg, Speaker Quinn, and the New York City Council for introducing legislation that will protect the health of all New Yorkers. I enjoy going to many beautiful parks in New York City and because of the negative effects of "second hand" smoke to my health I find it very important to ban smoking in parks, beaches and pedestrian malls.

Thank you for this opportunity to express my feelings on this matter.

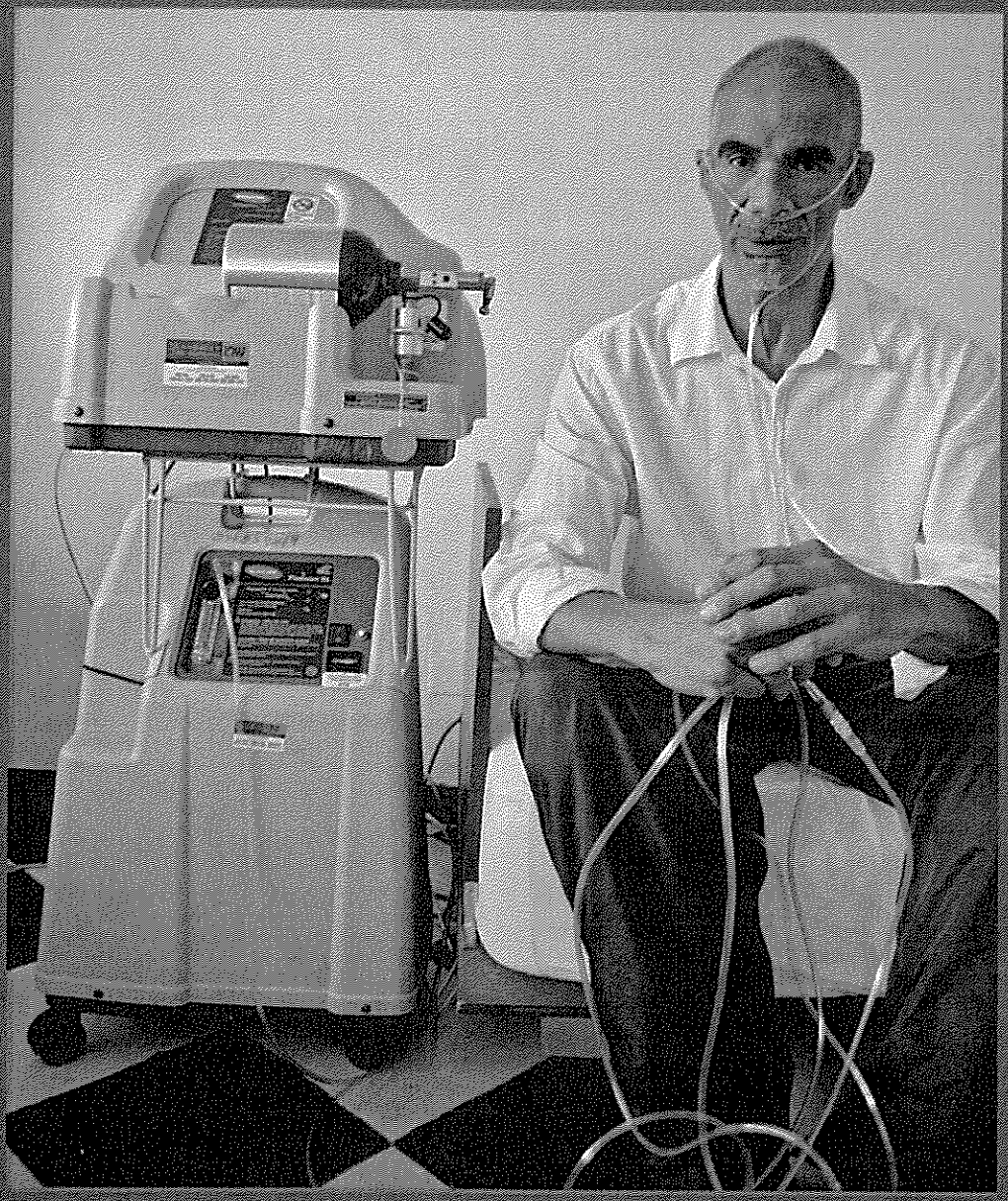
---

3 Barnoya, J and Glantz, SA (2005). Cardiovascular effects of secondhand smoke. *Circulation*: 111:2684-2698.

4 U.S. Dept. of Health and Human Services. "The Health Consequences of Involuntary Exposure to Tobacco Smoke: A Report of the Surgeon General: 6 Major Conclusions of the Surgeon General." Office on Smoking and Health, 2006.

5 Ellis JA, Gwynn C, Garg RK, Philburn R, Aldous KM, Perl SB, Thorpe L, Frieden TR. Secondhand smoke exposure among nonsmokers nationally and in New York City. Nicotine Tob Res. 2009 Apr;11(4):362-70. Epub 2009 Apr 7.

6 Ibid.



NOT QUITE READY TO QUIT?
Think again.

For more info or to register contact
SmokeFree Project Counselor Adam Steiner
@ 646 556-9300 x 485 or
e-mail at asteiner@gaycenter.org

Visit our link at: http//www.gaycenter.org/health/smokefree

Asian Americans for Equality
108-110 Norfolk Street • New York, NY 10002
Tel: 212-979-8381 • Fax: 212-979-8386 • www.aafe.org

NeighborWorks® CHARTERED MEMBER

New York City Council
Committees on Health and Parks and Recreation
Joint Public Hearing for Intro 332 to Prohibit Smoking in Public Places
October 14, 2010

Good Afternoon. My name is Douglas Nam Le and I am the Community Development and Partnership Manager at Asian Americans for Equality (AAFE). Established in 1974, AAFE is a non-profit community-based development and civil rights organization. AAFE serves thousands of seniors, low-income and working individuals and families each year, offering an array of programs that encompass the organization's comprehensive approach to community development.

I would like to thank the City Council for giving us the opportunity to express our support for Intro 332 which would prohibit smoking in city parks, pedestrian plazas and beaches. Public space is important to our physical health and well-being. Many New Yorkers refer to New York City parks as their backyards. However, for immigrant communities that live in cramped or overcrowded housing, we view parks as our "living rooms"—essential spaces that are part of our everyday lives. We need healthy and clean public spaces—that are smoke-free—where we can exercise, play, and socialize freely without worrying about second-hand smoke. I feel that this legislation will move us closer to that reality.

The prevalence of smoking, exposure to second-hand smoke and use of smoke-less tobacco are issues of concern in our communities. The NYC DOHMH reports 10.6% of Asian New Yorker smoke, which is lower than the percentage for all New Yorkers (15.8%). However community-based studies of tobacco use in New York's diverse Asian American community conducted by the NYU Center for the Study of Asian American Health have that shown smoking rates among Asian ethnic sub-groups vary widely. In New York City rates of smoking cigarettes range from as low as 12% among South Asians to as high as 32% among Koreans.

While nicotine replacement therapy and cessation programs have been the hallmark of the City's tobacco control work, Asian New Yorkers have the lowest rates of participation in nicotine replacement therapy than any other racial or ethnic group, according to data published by the NYC DOHMH.

The public health and environmental consequences of smoking and second-hand smoke are priorities for New York's Asian American communities. According to the New York State Cancer Registry, the incidence of and rate of death from lung cancer is highest for Asian men living in Manhattan and Brooklyn. The incidence of lung cancer is higher in Asian American neighborhoods such as Lower Manhattan, Sunset Park, Brooklyn, and Flushing and Jackson Heights, Queens, when compared to the overall incidence in each of their respective boroughs.

Asian Americans for Equality
108-110 Norfolk Street • New York, NY 10002
Tel: 212-979-8381 • Fax: 212-979-8386 • www.aafe.org

NeighborWorks®
CHARTERED MEMBER

One morning this past August, I worked with our Teen Action youth program to organize a clean-up of Columbus Park, in the heart of Chinatown. Most of the litter we picked up was not leaves or branches, but cigarette butts and matchbooks. Later that day, the park filled with hundreds of people sitting in the sun, listening to live music, exercising tai chi, and playing games. As all of this was happening, it was impossible to walk 10 feet without encountering heavy second hand smoke.

AAFE is committed to improving the quality of life for all residents, particularly the vulnerable. Intro 332 will protect community members, especially our children, from second-hand smoke, prevent litter in our public places, and motivate smokers to consider quitting. There have been concerns about how this law will be enforced and its impact on community relations with the NYPD. Situations have occurred in our community when the enforcement of park regulations—such as closing times and unpermitted vending—has escalated beyond Parks Enforcement Patrol (PEP), and has led to summons or arrests by the NYPD. AAFE has worked closely with the Parks Department to ensure equitable access to the city's parks, and will continue our work to make public spaces safe for everyone.

We urge the Council to consider the health and environmental benefits of this legislation. Once the legislation is passed, AAFE and our partners will work closely with our communities not only to ensure that our constituents are fully educated about how the smoking ban will be enforced and how they should cooperate with it, but how the ban will make our community a better place to live.

Thank you.

Testimony

Barbara Hart, MPA
Program Manager, Bronx BREATHES
Albert Einstein College of Medicine of Yeshiva University

Local Law 332-2010, Prohibiting Smoking in Pedestrian Plazas and Public Parks.

Testimony Before
The New York City Council

Thursday, October 14, 2010
250 Broadway – 14th Floor
New York, New York

Good afternoon, members of the City Council, I am Barbara Hart, Program Manager, Bronx BREATHES, the Bronx Tobacco Cessation Center. Thank you for the opportunity to discuss such an important issue.

September 15, 2010, the Mayor held a press conference to announce plans to expand the Smoke Free Air Act in New York City to include parks and beaches. I commend the Mayor for his efforts to guarantee the right of all New Yorkers to safe, smoke free parks, pedestrian plazas and beaches.

Second-hand smoke (SHS) is an environmental toxin. Exposure to second-hand smoke causes heart disease and lung cancer, killing hundreds of New Yorkers every year. There is **no safe level of SHS exposure**. Even brief exposure to SHS can result in upper airway changes in healthy persons[1] and lead to more frequent asthma attacks in asthmatic children.[2] Just 30 minutes of exposure changes the way your blood clots and your blood vessels react in a way that increases the risk of heart disease. Each year in the United States, SHS exposure is responsible for 150,000–300,000 new cases of bronchitis and pneumonia in children aged less than 18 months. This results in 7,500–15,000 hospitalizations, annually.[3]

Second-hand smoke is an outdoor hazard whether you are taking a walk through Crotona Park or sitting on the Orchard Beach board walk enjoying the sun eating popcorn. Cigarettes are the number one source of beach litter and do not easily biodegrade.[4] Cigarette butts have been shown to be **toxic, slow to decompose, costly to manage**, and growing in volume.[5] Thousands of non-smoking New Yorkers and visitors are exposed to second-hand smoke all or most of the time simply walking through the park or waiting for a bus. Outdoor air regulations are needed to protect the public health of all New Yorkers. Many New Yorkers are members of minority groups who are poorly paid and may not have the health insurance to pay for resulting adverse affects of SHS. However, we are continually exposed to the hazards of second-hand smoke because we like walking through the parks and pedestrian plazas in our city.

I give you the responsibility as my legislative representatives in government to protect the health and safety of all New Yorkers and the public at large.

In our society laws are created to protect people from threats to health and safety. Public health laws modifying individual behavior were born of an understanding that freedom is not absolute. The Outdoor Air Act does not deny the right of smokers to smoke; it asserts that the right of New Yorkers to breathe smoke-free air without known carcinogens and toxins serves a greater good than the desire of smokers to smoke anywhere and at any time.

Please vote to enact local law 332-2010, prohibiting smoking in pedestrian plazas and public parks.

---

1 U.S. Dept. of Health and Human Services. "The Health Consequences of Involuntary Exposure to Tobacco Smoke: A Report of the Surgeon General: 6 Major Conclusions of the Surgeon General." Office on Smoking and Health, 2006.

2 Ibid.

3 United States Environmental Protection Agency. Respiratory Health Effects of Passive Smoking: Lung Cancer and Other Disorders. Office of Research and Development, EPA/600/6-90/006F, Washington, D.C., December 1992 [accessed 2006 Sep 27].

4 Ocean Conservancy, 2009. Retrieved from http://www.oceanconservancy.org/site/News2?page=NewsArticle&id=12551&news_iv_ctrl=0&abbr=icc_

5 http://www.cigwaste.org/index.php/Research/

Good afternoon, everyone

My name is Jose Gonzalez I live with my two children and my wife in the Highbridge section of the Bronx. And I'm representing the **Smoke-Free Public Parks and Beaches in the Bronx.**

Cigarettes have been killing millions of people around the world, and here in United States the cigarettes is leading the cause of death taking the live of more than 435,000 people.

Many children are born or get diseases from what is called Second Hand Smoke, where nonsmokers inhaling smoke in difference places such as restaurants, shopping centers, on the street but also in playgrounds and parks where smokers visit and smoke close to children, seniors, youngsters whom also have asthma or other medical critical condition that can even sometimes cause their death.

Tobacco kills more than any other disease nationwide and in NYC Kills more deaths than AIDS.

Worldwide, tobacco use causes more than 5 million deaths per year, and current trends show that tobacco use will cause more than 8 million deaths annually by 2030.3

In the United States, tobacco use is responsible for about one in five deaths annually and an estimated 49,000 of these tobacco-related deaths are the result of secondhand smoke exposure.

On average, smokers die 13 to 14 years earlier than nonsmokers.

Tobacco use leads to disease and disability.

Smoking causes cancer, heart disease, stroke, and lung diseases (including emphysema, bronchitis, and chronic airway obstruction).

For every person who dies from a smoking-related disease, 20 more people suffer with at least one serious illness from smoking.

How are neighborhoods, families and children protected from these diseases when we are expose to secondhand smoking in all NYC parks and playgrounds

The Bronx is the Borough with highest Asthma Hospitalization Rate on age from 0-14 compare with all boroughs in NYC and the Highbridge-Morrisania is leading the highest Neighborhood with Asthma Hospitalization Rate 11.02 following Huntspiont-Mount Haven with 10.00 and as we know these are low income neighborhoods.

As father it's my responsibility to teach my kids that their mom and dad don't smoke, I've seen advertised campaign for people to quit smoke, but I think we should do more by giving healthy parks and public places to our new generation, by having a healthy environment for people whom want be part of a healthy country.

Our children and family deserve a healthy life, and a Legislation in NYC that protects families and environments and legislation that will give us more time to hold our lives but our families as well.

Science or Scientific Fiction?

Analysis of the 2006 Surgeon General's Report

Prepared by:

Chris McCalla
Legislative Director

International Premium Cigar & Pipe Retailers Association
4 Bradley Park Court
Suite 2H
Columbus GA 31904-3637

legislative@ipcpr.org
www.ipcpr.org

IPCPR Analysis and Rebuttal Statement of 2006 Surgeon General's Report:

The 2006 Surgeon General's Report and its accompanying Executive Summary clearly conclude that second-hand smoke should not be considered a legitimate health or environmental hazard. Media reports, statements made by anti-tobacco groups and even press releases from the Surgeon General's office contradict the actual findings of the Report.

The U.S. Department of Health and Human Services (HHS) released the Surgeon General's report in two forms—an ***Executive Summary*** (27 pages), and ***Full Report*** (707 pages). The *Executive Summary*, an abridged version of the *Full Report*, summarizes the key points and claims stated in the Full Report.

For this analysis, the Executive Summary (ES) was reviewed and the following points lead to the conclusion that this latest Surgeon General's report, like those previously issued, is inconclusive in its claims regarding secondhand smoke, contrary to information reported by the media and anti-tobacco groups.

In analyzing both the *ES* and *Full Report*, it is imperative to note that, despite the overall claims made by the media and anti-smoking groups, much of the research proves to be inconclusive. Two key phrases are used throughout the *ES* and *Full Report that* call attention to the inconclusive results of their research:

Phrase One: "*The evidence is inadequate* to [infer, suggest, or relate various health issues to secondhand smoke]"

> This phrase appears 17 times in the *ES* and 52 times in the *Full Report*.

Phrase Two: "The evidence is suggestive but not sufficient to [infer, suggest, or relate various health issues to secondhand smoke]"

> This phrase appears 19 times in the *ES* and 56 times in the *Full Report*.

Additional key points not employing either of these key phrases include, and are not limited to the following conclusions:

> *Individual biomarkers of exposure to secondhand smoke represent only one component of a complex mixture, and measurements of one marker* ***may not wholly reflect*** *an exposure to other components of concern as a result of involuntary smoking.* (Page 10, Chapter 3 conclusion, point #8)
>
> The evidence indicates mechanisms by which secondhand smoke exposure ***could*** *(note the word choice "could"; nothing definitive)* increase the risk for sudden infant death syndrome. (Page 10, Chapter 2, point #6)

The Report also contains additional contradictions as demonstrated by the following points:

The evidence is inadequate to infer the presence or absence of a causal relationship between exposure to secondhand smoke and neonatal (a newborn infant up to age one month) mortality. (Page 11, Chapter 5, point #3)

Contradicts the following point:

The evidence is sufficient to infer a causal relationship between exposure to secondhand smoke and sudden infant death syndrome. (Page 11, Chapter 5, point #4)

Sudden Infant Death Syndrome (SIDS) (any sudden and unexplained death of an apparently healthy infant aged one month to one year) as stated in point #4 includes neonatal mortality as stated in point #3.

Other points throughout the Chapter 5 summary prove no conclusive link to infant and childhood development, malformation, or ailments related to secondhand smoke.

As stated in Chapter 9, other than *odor annoyance* (page 13, Chapter 9, point #1), there is no conclusive evidence of a causal relationship between secondhand smoke and adult illnesses.

Air Filtration and Purification Not Specifically Addressed

The Surgeon General's Report discussed at length air exchange and its ineffectiveness of clearing secondhand smoke from indoor spaces. It does not give consideration to today's technologically advanced air filtration and purification systems.

Rebuttal Summary:

After evaluation of the *ES* and *Full Report*, the Surgeon General's report on the effects of secondhand smoke may be labeled as non-conclusive at best.

The Surgeon General's position and interpretation of the research on secondhand smoke is presented as a *Zero-sum* game—that this issue is solely black-and-white with no room for error or deviation (despite available evidence to the contrary listed in this report and through publicly-accessible research papers and other documentation.

The Health Consequences of Involuntary Exposure to Tobacco Smoke

A Report of the Surgeon General

Department of Health and Human Services

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

Suggested Citation

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

To download copies of this document from the Web:

Go to http://www.cdc.gov/tobacco

To order single copies of this document:

Call toll free 1-800-CDC-INFO (1-800-232-4636). Information is available in English and Spanish, 24 hours/day, 7 days/week.
For text telephone for hearing impaired, dial 1-888-232-6348.

For more information about this document:

E-mail tobaccoinfo@cdc.gov.

Copies of the full report (stock no. 017-024-01685-3) may be purchased from:

Superintendent of Documents
U.S. Government Printing Office
P.O. Box 371954
Pittsburgh, PA 15250-7954
Toll-free: 1-866-512-1800
Web site: http://bookstore.gpo.gov.

The Health Consequences of Involuntary Exposure to Tobacco Smoke

A Report of the Surgeon General

2006

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

Executive Summary

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

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

The 1979 Surgeon General's report, *Smoking and Health: A Report of the Surgeon General* (USDHEW 1979), also contained a chapter entitled "Involuntary Smoking." The chapter stressed that "attention to involuntary smoking is of recent vintage, and only limited information regarding the health effects of such exposure upon the nonsmoker is available" (p. 11–35). The chapter concluded with recommendations for research including epidemiologic and clinical studies. The 1982 Surgeon General's report specifically addressed smoking and cancer (U.S. Department of Health and Human Services [USDHHS] 1982). By 1982, there were three published epidemiologic studies on involuntary smoking and lung cancer, and the 1982 Surgeon General's report included a brief chapter on this topic. That chapter commented on the methodologic difficulties inherent in such studies, including exposure assessment, the lengthy interval during which exposures are likely to be relevant, and accounting for exposures to other carcinogens. Nonetheless, the report concluded that "Although the currently available evidence is not sufficient to conclude that passive or involuntary smoking causes lung cancer in nonsmokers, the evidence does raise concern about a possible serious public health problem" (p. 251).

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

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

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

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

Table 1.1 Continued

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

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

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

Two other reports published in 1986 also reached the conclusion that involuntary smoking increased the risk for lung cancer. The International Agency for Research on Cancer (IARC) of the World Health Organization concluded that "passive smoking gives rise to some risk of cancer" (IARC 1986, p. 314). In its monograph on tobacco smoking, the agency supported this conclusion on the basis of the characteristics of sidestream and mainstream smoke, the absorption of tobacco smoke materials during an involuntary exposure, and the nature of dose-response relationships for carcinogenesis. In the same year, the National Research Council (NRC) also concluded that involuntary smoking increases the incidence of lung cancer in nonsmokers (NRC 1986). In reaching this conclusion, the NRC report cited the biologic plausibility of the association between exposure to secondhand smoke and lung cancer and the supporting epidemiologic evidence. On the basis of a pooled analysis of the epidemiologic data adjusted for bias, the report concluded that the best estimate for the excess risk of lung cancer in nonsmokers married to smokers was 25 percent, compared with nonsmokers married to nonsmokers. With regard to the effects of involuntary smoking on children, the NRC report commented on the literature linking secondhand smoke exposures from parental smoking to increased risks for respiratory symptoms and infections and to a slightly diminished rate of lung growth.

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

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

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

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

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

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

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

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

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

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

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

Organization of the Report

This twenty-ninth report of the Surgeon General examines the topics of toxicology of secondhand smoke, assessment and prevalence of exposure to secondhand smoke, reproductive and developmental health effects, respiratory effects of exposure to secondhand smoke in children and adults, cancer among adults, cardiovascular diseases, and the control of secondhand smoke exposure.

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

Preparation of the Report

This report of the Surgeon General was prepared by the Office on Smoking and Health, National Center for Chronic Disease Prevention and Health Promotion, Coordinating Center for Health Promotion, Centers for Disease Control and Prevention (CDC), and U.S. DHHS. Initial chapters were written by 22 experts who were selected because of their knowledge of a particular topic. The contributions of the initial experts were consolidated into 10 major chapters that were then reviewed by more than 40 peer reviewers. The entire manuscript was then sent to more than 30 scientists and experts who reviewed it for its scientific integrity. After each review cycle, the drafts were revised by the scientific editors on the basis of the experts' comments. Subsequently, the report was reviewed by various institutes and agencies within U.S. DHHS. Publication lags, even short ones, prevent an up-to-the-minute inclusion of all recently published articles and data. Therefore, by the time the public reads this report, there may be additional published studies or data. To provide published information as current as possible, this report includes an Appendix of more recent studies that represent major additions to the literature.

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

Definitions and Terminology

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

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

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

Evidence Evaluation

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

In the 2004 report of the Surgeon General, *The Health Consequences of Smoking*, the framework for interpreting evidence on smoking and health was revisited in depth for the first time since the 1964 report (USDHHS 2004). The 2004 report provided a four-level hierarchy for interpreting evidence (Table 1.4). The categories acknowledge that evidence can be "suggestive" but not adequate to infer a causal relationship, and also allows for evidence that is "suggestive of no causal relationship." Since the 2004 report, the individual chapter conclusions have consistently used this four-level hierarchy (Table 1.4), but evidence syntheses and other summary statements may use either the term "increased risk" or "cause" to describe instances in which there is sufficient evidence to conclude that active or involuntary smoking causes a disease or condition. This four-level framework also sharply and completely separates conclusions regarding causality from the implications of such conclusions.

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

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

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

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

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

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

Major Conclusions

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

1. Secondhand smoke causes premature death and disease in children and in adults who do not smoke.

2. Children exposed to secondhand smoke are at an increased risk for sudden infant death syndrome (SIDS), acute respiratory infections, ear problems, and more severe asthma. Smoking by parents causes respiratory symptoms and slows lung growth in their children.

3. Exposure of adults to secondhand smoke has immediate adverse effects on the cardiovascular system and causes coronary heart disease and lung cancer.

4. The scientific evidence indicates that there is no risk-free level of exposure to secondhand smoke.

5. Many millions of Americans, both children and adults, are still exposed to secondhand smoke in their homes and workplaces despite substantial progress in tobacco control.

6. Eliminating smoking in indoor spaces fully protects nonsmokers from exposure to secondhand smoke. Separating smokers from nonsmokers, cleaning the air, and ventilating buildings cannot eliminate exposures of nonsmokers to secondhand smoke.

Chapter Conclusions

Chapter 2. Toxicology of Secondhand Smoke

Evidence of Carcinogenic Effects from Secondhand Smoke Exposure

1. More than 50 carcinogens have been identified in sidestream and secondhand smoke.

2. The evidence is sufficient to infer a causal relationship between exposure to secondhand smoke and its condensates and tumors in laboratory animals.

3. The evidence is sufficient to infer that exposure of nonsmokers to secondhand smoke causes a significant increase in urinary levels of metabolites of the tobacco-specific lung carcinogen 4-(methylnitrosamino)-1-(3-pyridyl)-1-butanone (NNK). The presence of these metabolites links exposure to secondhand smoke with an increased risk for lung cancer.

4. The mechanisms by which secondhand smoke causes lung cancer are probably similar to those observed in smokers. The overall risk of secondhand smoke exposure, compared with active smoking, is diminished by a substantially lower carcinogenic dose.

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

5. The evidence indicates multiple mechanisms by which secondhand smoke exposure causes injury to the respiratory tract.

6. The evidence indicates mechanisms by which secondhand smoke exposure could increase the risk for sudden infant death syndrome.

Mechanisms of Secondhand Smoke Exposure and Heart Disease

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

8. The evidence is sufficient to infer that exposure to secondhand smoke causes endothelial cell dysfunctions.

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

Chapter 3. Assessment of Exposure to Secondhand Smoke

Building Designs and Operations

1. Current heating, ventilating, and air conditioning systems alone cannot control exposure to secondhand smoke.

2. The operation of a heating, ventilating, and air conditioning system can distribute secondhand smoke throughout a building.

Exposure Models

3. Atmospheric concentration of nicotine is a sensitive and specific indicator for secondhand smoke.

4. Smoking increases indoor particle concentrations.

5. Models can be used to estimate concentrations of secondhand smoke.

Biomarkers of Exposure to Secondhand Smoke

6. Biomarkers suitable for assessing recent exposures to secondhand smoke are available.

7. At this time, cotinine, the primary proximate metabolite of nicotine, remains the biomarker of choice for assessing secondhand smoke exposure.

8. Individual biomarkers of exposure to secondhand smoke represent only one component of a complex mixture, and measurements of one marker may not wholly reflect an exposure to other components of concern as a result of involuntary smoking.

Chapter 4. Prevalence of Exposure to Secondhand Smoke

1. The evidence is sufficient to infer that large numbers of nonsmokers are still exposed to secondhand smoke.

2. Exposure of nonsmokers to secondhand smoke has declined in the United States since the 1986 Surgeon General's report, *The Health Consequences of Involuntary Smoking*.

3. The evidence indicates that the extent of secondhand smoke exposure varies across the country.

4. Homes and workplaces are the predominant locations for exposure to secondhand smoke.

5. Exposure to secondhand smoke tends to be greater for persons with lower incomes.

6. Exposure to secondhand smoke continues in restaurants, bars, casinos, gaming halls, and vehicles.

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

Fertility

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

Pregnancy (Spontaneous Abortion and Perinatal Death)

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

Infant Deaths

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

Sudden Infant Death Syndrome

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

Preterm Delivery

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

Low Birth Weight

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

Congenital Malformations

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

Cognitive Development

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

Behavioral Development

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

Height/Growth

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

Childhood Cancer

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

12. The evidence is inadequate to infer the presence or absence of a causal relationship between maternal exposure to secondhand smoke during pregnancy and childhood cancer.

13. The evidence is inadequate to infer the presence or absence of a causal relationship between exposure to secondhand smoke during infancy and childhood cancer.

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

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

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

17. The evidence is inadequate to infer the presence or absence of a causal relationship between prenatal and postnatal exposure to secondhand smoke and other childhood cancer types.

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

Lower Respiratory Illnesses in Infancy and Early Childhood

1. The evidence is sufficient to infer a causal relationship between secondhand smoke exposure from parental smoking and lower respiratory illnesses in infants and children.

2. The increased risk for lower respiratory illnesses is greatest from smoking by the mother.

Middle Ear Disease and Adenotonsillectomy

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

4. The evidence is suggestive but not sufficient to infer a causal relationship between parental smoking and the natural history of middle ear effusion.

5. The evidence is inadequate to infer the presence or absence of a causal relationship between parental smoking and an increase in the risk of adenoidectomy or tonsillectomy among children.

Respiratory Symptoms and Prevalent Asthma in School-Age Children

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

7. The evidence is sufficient to infer a causal relationship between parental smoking and ever having asthma among children of school age.

Childhood Asthma Onset

8. The evidence is sufficient to infer a causal relationship between secondhand smoke exposure from parental smoking and the onset of wheeze illnesses in early childhood.

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

Atopy

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

Lung Growth and Pulmonary Function

11. The evidence is sufficient to infer a causal relationship between maternal smoking during pregnancy and persistent adverse effects on lung function across childhood.

12. The evidence is sufficient to infer a causal relationship between exposure to secondhand smoke after birth and a lower level of lung function during childhood.

Chapter 7. Cancer Among Adults from Exposure to Secondhand Smoke

Lung Cancer

1. The evidence is sufficient to infer a causal relationship between secondhand smoke exposure and lung cancer among lifetime nonsmokers. This conclusion extends to all secondhand smoke exposure, regardless of location.

2. The pooled evidence indicates a 20 to 30 percent increase in the risk of lung cancer from secondhand smoke exposure associated with living with a smoker.

Breast Cancer

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

Nasal Sinus Cavity and Nasopharyngeal Carcinoma

4. The evidence is suggestive but not sufficient to infer a causal relationship between secondhand smoke exposure and a risk of nasal sinus cancer among nonsmokers.

5. The evidence is inadequate to infer the presence or absence of a causal relationship between secondhand smoke exposure and a risk of nasopharyngeal carcinoma among nonsmokers.

Cervical Cancer

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

Chapter 8. Cardiovascular Diseases from Exposure to Secondhand Smoke

1. The evidence is sufficient to infer a causal relationship between exposure to secondhand smoke and increased risks of coronary heart disease morbidity and mortality among both men and women.

2. Pooled relative risks from meta-analyses indicate a 25 to 30 percent increase in the risk of coronary heart disease from exposure to secondhand smoke.

3. The evidence is suggestive but not sufficient to infer a causal relationship between exposure to secondhand smoke and an increased risk of stroke.

4. Studies of secondhand smoke and subclinical vascular disease, particularly carotid arterial wall thickening, are suggestive but not sufficient to infer a causal relationship between exposure to secondhand smoke and atherosclerosis.

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

Odor and Irritation

1. The evidence is sufficient to infer a causal relationship between secondhand smoke exposure and odor annoyance.

2. The evidence is sufficient to infer a causal relationship between secondhand smoke exposure and nasal irritation.

3. The evidence is suggestive but not sufficient to conclude that persons with nasal allergies or a history of respiratory illnesses are more susceptible to developing nasal irritation from secondhand smoke exposure.

Respiratory Symptoms

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

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

6. The evidence is suggestive but not sufficient to infer a causal relationship between secondhand smoke exposure and chronic respiratory symptoms.

Lung Function

7. The evidence is suggestive but not sufficient to infer a causal relationship between short-term secondhand smoke exposure and an acute decline in lung function in persons with asthma.

8. The evidence is inadequate to infer the presence or absence of a causal relationship between short-term secondhand smoke exposure and an acute decline in lung function in healthy persons.

9. The evidence is suggestive but not sufficient to infer a causal relationship between chronic secondhand smoke exposure and a small decrement in lung function in the general population.

10. The evidence is inadequate to infer the presence or absence of a causal relationship between chronic secondhand smoke exposure and an accelerated decline in lung function.

Asthma

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

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

Chronic Obstructive Pulmonary Disease

13. The evidence is suggestive but not sufficient to infer a causal relationship between secondhand smoke exposure and risk for chronic obstructive pulmonary disease.

14. The evidence is inadequate to infer the presence or absence of a causal relationship between secondhand smoke exposure and morbidity in persons with chronic obstructive pulmonary disease.

Chapter 10. Control of Secondhand Smoke Exposure

1. Workplace smoking restrictions are effective in reducing secondhand smoke exposure.

2. Workplace smoking restrictions lead to less smoking among covered workers.

3. Establishing smoke-free workplaces is the only effective way to ensure that secondhand smoke exposure does not occur in the workplace.

4. The majority of workers in the United States are now covered by smoke-free policies.

5. The extent to which workplaces are covered by smoke-free policies varies among worker groups, across states, and by sociodemographic factors. Workplaces related to the entertainment and hospitality industries have notably high potential for secondhand smoke exposure.

6. Evidence from peer-reviewed studies shows that smoke-free policies and regulations do not have an adverse economic impact on the hospitality industry.

7. Evidence suggests that exposure to secondhand smoke varies by ethnicity and gender.

8. In the United States, the home is now becoming the predominant location for exposure of children and adults to secondhand smoke.

9. Total bans on indoor smoking in hospitals, restaurants, bars, and offices substantially reduce secondhand smoke exposure, up to several orders of magnitude with incomplete compliance, and with full compliance, exposures are eliminated.

10. Exposures of nonsmokers to secondhand smoke cannot be controlled by air cleaning or mechanical air exchange.

Methodologic Issues

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

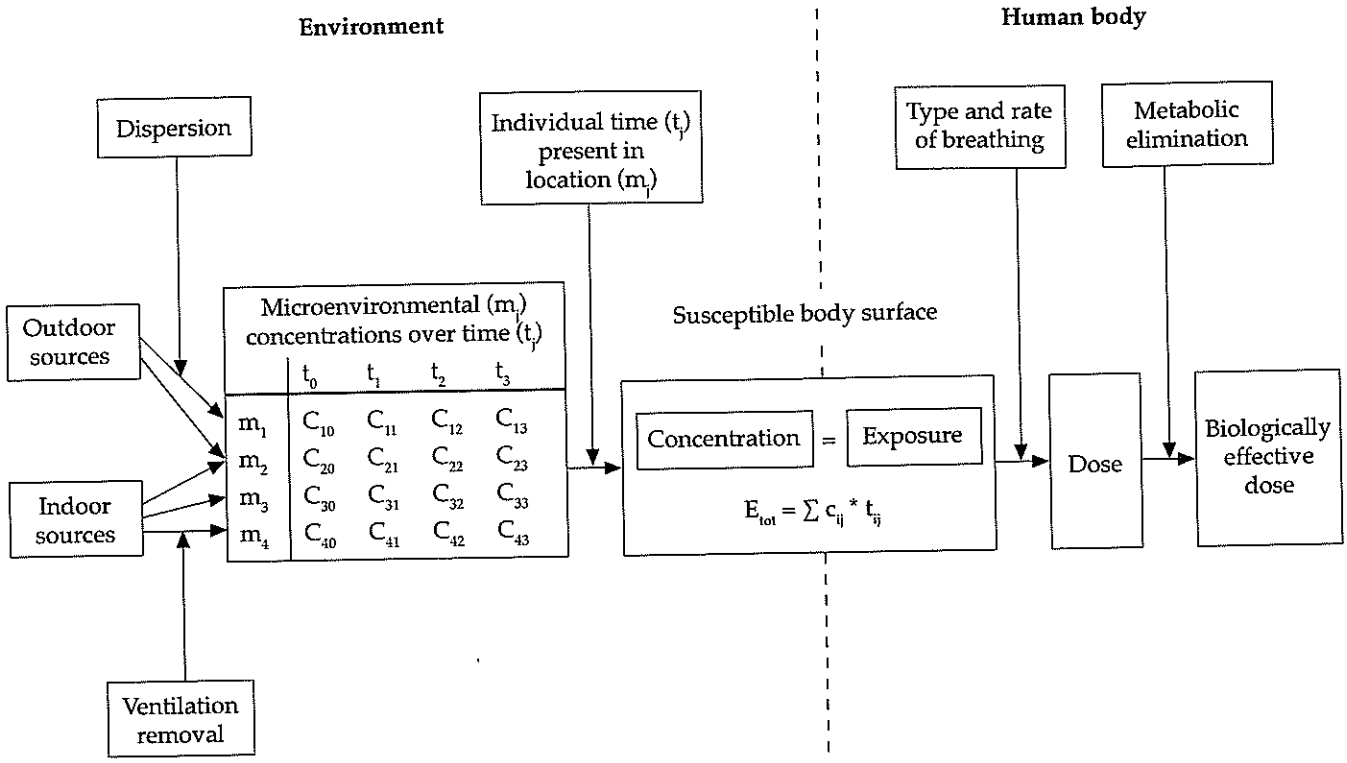
Classification of Secondhand Smoke Exposure

For secondhand smoke, as for any environmental factor that may be a cause of disease, the exposure assessment might encompass the time and place of the exposure, cumulative exposures, exposure during a particular time, or a recent exposure (Jaakkola and Jaakkola 1997; Jaakkola and Samet 1999). For example, exposures to secondhand smoke across the full life span may be of interest for lung cancer, while only more recent exposures may be relevant to the exacerbation of asthma. For CHD, both temporally remote and current exposures may affect risk. Assessments of exposures are further complicated by the multiplicity of environments where exposures take place and the difficulty of characterizing the exposure in some locations, such as public places or workplaces. Additionally, exposures probably vary qualitatively and quantitatively over time and across locations because of temporal changes and geographic differences in smoking patterns.

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

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

Figure 1.1 The determinants of exposure, dose, and biologically effective dose that underlie the development of health effects from smoking



Source: Samet and Jaakkola 1999. Reprinted with permission.

on the microenvironmental model, total exposure can be estimated as the weighted average of the concentrations of secondhand smoke or indicator compounds, such as nicotine, in the microenvironments where time is spent; the weights are the time spent in each microenvironment. Klepeis (1999) illustrates the application of the microenvironmental model with national data from the National Human Activity Pattern Survey conducted by the EPA. His calculations yield an overall estimate of exposure to airborne particles from smoking and of the contributions to this exposure from various microenvironments.

Much of the epidemiologic evidence addresses the consequences of an exposure in a particular microenvironment, such as the home (spousal smoking and lung cancer risk or maternal smoking and risk for asthma exacerbation), or the workplace (exacerbation of asthma by the presence of smokers). Some studies have attempted to cover multiple microenvironments and to characterize exposures over time. For example, in the multicenter study of secondhand smoke exposure and lung cancer carried out in the United States, Fontham and colleagues (1994) assessed exposures during childhood, in workplaces, and at home during adulthood. Questionnaires that assess exposures have been the primary tool used in epidemiologic studies of secondhand smoke and disease. Measurement of biomarkers has been added in some studies, either as an additional and complementary exposure assessment approach or for validating questionnaire responses. Some studies have also measured components of secondhand smoke in the air.

Questionnaires generally address sources of exposure in microenvironments and can be tailored to address the time period of interest. Questionnaires represent the only approach that can be used to assess exposures retrospectively over a life span, because available biomarkers only reflect exposures

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

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

Biomarkers are also used for assessing exposures to secondhand smoke. A number of biomarkers are available, but they vary in their specificity and in the dynamics of the temporal relationship between the exposure and the marker level (Cal/EPA 1997; Benowitz 1999). These markers include specific tobacco smoke components (nicotine) or metabolites (cotinine and tobacco-specific nitrosamines), nonspecific biomarkers (thiocyanate and CO), adducts with tobacco smoke components or metabolites (4-aminobiphenyl–hemoglobin adducts, benzo[*a*]pyrene–DNA adducts, and polycyclic aromatic hydrocarbon–albumin adducts), and nonspecific assays (urinary mutagenicity). Cotinine has been the most widely used biomarker, primarily because of its specificity, half-life, and ease of measurement in body fluids (e.g., urine, blood, and saliva). Biomarkers are discussed in detail in Chapter 3 (Assessment of Exposure to Secondhand Smoke).

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

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

Misclassification of Secondhand Smoke Exposure

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

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

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

One particular form of misclassification has been raised with regard to secondhand smoke exposure and lung cancer: the classification of some current or former smokers as lifetime nonsmokers (USEPA 1992; Lee and Forey 1995; Hackshaw et al. 1997; Wu 1999). The resulting bias would tend to increase the apparent association of secondhand smoke with lung cancer, if the misclassified active smokers are also more likely to be classified as involuntary smokers. Most studies of lung cancer and secondhand smoke have used spousal smoking as a main exposure variable. As smoking tends to aggregate between spouses (smokers are more likely to marry smokers), misclassification of active smoking would tend to be differential on the basis of spousal smoking (the exposure under investigation). Because active smoking is strongly associated with increased disease risk, greater misclassification of an actively smoking spouse as a nonsmoker among spouses of smokers compared with spouses of nonsmokers would lead to risk estimates for spousal smoking that are biased upward by the effect of active smoking. This type of misclassification is also relevant to studies of spousal exposure and CHD risk or other diseases also caused by active smoking, although the potential for bias is less because the association of active smoking with CHD is not as strong as with lung cancer.

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

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

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

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

Use of Meta-Analysis

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

Beginning with the 1986 NRC report, meta-analysis has been used to summarize the evidence on involuntary smoking and health. Meta-analysis was central to the 1992 EPA risk assessment of secondhand smoke, and a series of meta-analyses supported the conclusions of the 1998 report of the Scientific Committee on Tobacco and Health in the United Kingdom. The central role of meta-analysis in interpreting and applying the evidence related to involuntary smoking and disease has led to focused criticisms of the use of meta-analysis in this context. Several papers that acknowledged support from the tobacco industry have addressed the epidemiologic findings for lung cancer, including the selection and quality of the studies, the methods for meta-analysis, and dose-response associations (Fleiss and Gross 1991; Tweedie and Mengersen 1995; Lee 1998, 1999). In a lawsuit brought by the tobacco industry against the EPA, the 1998 decision handed down by Judge William L. Osteen, Sr., in the North Carolina Federal District Court criticized the approach EPA had used to select studies for its meta-analysis and criticized the use of 90 percent rather than 95 percent confidence intervals for the summary estimates (*Flue-Cured Tobacco Cooperative Stabilization Corp. v. United States Environmental Protection Agency*, 857 F. Supp. 1137 [M.D.N.C. 1993]). In December 2002, the 4th U.S. Circuit Court of Appeals threw out the lawsuit on the basis that tobacco companies cannot sue the EPA over its secondhand smoke report because the report was not a final agency action and therefore not subject to court review (*Flue-Cured Tobacco Cooperative Stabilization Corp. v. The United States Environmental Protection Agency*, No. 98-2407 [4th Cir., December 11, 2002], *cited in* 17.7 TPLR 2.472 [2003]).

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

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

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

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

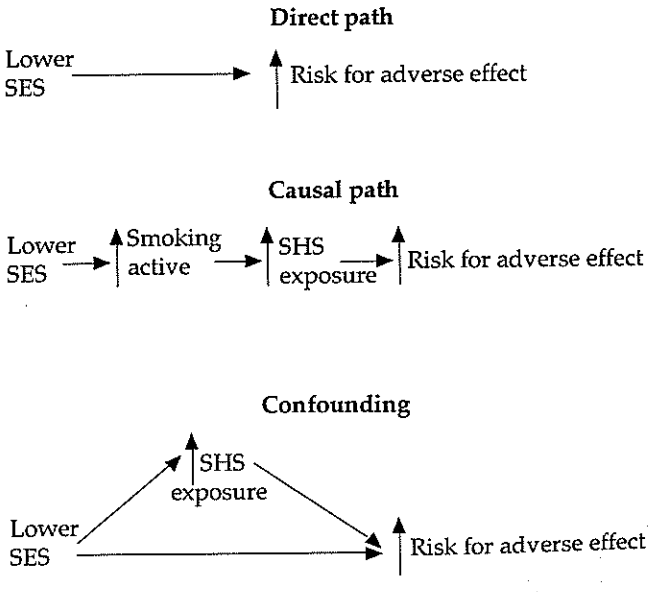
The quantitative results of the meta-analyses, however, were not determinate in making causal inferences in this Surgeon General's report. In particular, the level of statistical significance of estimates from the meta-analyses was not a predominant factor in making a causal conclusion. For that purpose,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

Confounding

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

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

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



Arrows indicate directionality of association.

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

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

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

Tobacco Industry Activities

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

Industry documents indicate that the tobacco industry has engaged in widespread activities, however, that have gone beyond the bounds of accepted scientific practice (Glantz 1996; Ong and Glantz 2000, 2001; Rampton and Stauber 2000; Yach and Bialous 2001; Hong and Bero 2002; Diethelm et al. 2004). Through a variety of organized tactics, the industry has attempted to undermine the credibility of the scientific evidence on secondhand smoke. The industry has funded or carried out research that has been judged to be biased, supported scientists to generate letters to editors that criticized research publications, attempted to undermine the findings of key studies, assisted in establishing a scientific society with a journal, and attempted to sustain controversy even as the scientific community reached consensus (Garne et al. 2005). These tactics are not a topic of this report, but to the extent that the scientific literature has been distorted, they are addressed as the evidence is reviewed. This report does not specifically identify tobacco industry sponsorship of publications unless that information is relevant to the interpretation of the findings and conclusions.

A Vision for the Future

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

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

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

As the adverse health consequences of active smoking became more widely documented in the 1960s, many people began to question whether exposure of nonsmokers to secondhand smoke also posed a serious health risk. This topic was first addressed in this series of reports by Surgeon General Jesse Steinfeld in the 1972 report to Congress (USDHEW 1972). During the 1970s, policy changes to provide smoke-free environments received more widespread consideration. As the public policy debate grew and expanded in the 1980s, the scientific evidence on the risk of adverse effects from exposure to secondhand smoke was presented in a comprehensive context for the first time by Surgeon General C. Everett Koop in the 1986 report, *The Health Consequences of Involuntary Smoking* (U.S. Department of Health and Human Services [USDHHS] 1986).

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

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

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

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

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

- Because active smoking is firmly established as a causal factor of cancer for a large number of sites, and because many scientists assert that there may be no threshold for carcinogenesis from tobacco smoke exposure, researchers hypothesize that people who are exposed to secondhand smoke are likely to be at some risk for the same types of cancers that have been established as smoking-related among active smokers.

- The potential risks for stroke and subclinical vascular disease from secondhand smoke exposure require additional research.

- There is a need for additional research on the etiologic relationship between secondhand smoke exposure and several respiratory health outcomes in adults, including respiratory symptoms, declines in lung function, and adult-onset asthma.

- There is also a need for research to further evaluate the adverse reproductive outcomes and childhood respiratory effects from both prenatal and postnatal exposure to secondhand smoke.

- Further research and improved methodologies are also needed to advance an understanding of the potential effects on cognitive, behavioral, and physical development that might be related to early exposures to secondhand smoke.

As these and other research questions are addressed, the scientific literature documenting the adverse health effects of exposure to secondhand smoke will expand. Over the past 40 years since the release of the landmark 1964 report of the Surgeon General's Advisory Committee on Smoking and Health (USDHEW 1964), researchers have compiled an ever-growing list of adverse health effects caused by exposure to tobacco smoke, with evidence that active smoking causes damage to virtually every organ of the body (USDHHS 2004). Similarly, since the 1986 report (USDHHS 1986), the number of adverse health effects caused by exposure to secondhand smoke has also expanded. Following the format of the electronic database released with the 2004 report, the research findings supporting the conclusions in this report will be accessible in a database that can be found at http://www.cdc.gov/tobacco. With an this expanding base of scientific knowledge, the list of adverse health effects caused by exposure to secondhand smoke will likely increase.

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

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

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

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

References

Armstrong BK, White E, Saracci R, editors. *Principles of Exposure Measurement in Epidemiology.* Monographs in Epidemiology and Biostatistics. Vol. 21. New York: Oxford University Press, 1992.

Benowitz NL. Biomarkers of environmental tobacco smoke. *Environmental Health Perspectives* 1999;107(Suppl 2):349–55.

Bero LA, Glantz SA, Rennie D. Publication bias and public health policy on environmental tobacco smoke. *Journal of the American Medical Association* 1994;272(2):133–6.

California Environmental Protection Agency. *Health Effects of Exposure to Environmental Tobacco Smoke.* Sacramento (CA): California Environmental Protection Agency, Office of Environmental Health Hazard Assessment, Reproductive and Cancer Hazard Assessment Section and Air Toxicology and Epidemiology Section, 1997.

California Environmental Protection Agency. *Proposed Identification of Environmental Tobacco Smoke as a Toxic Air Contaminant. Part B: Health Effects.* Sacramento (CA): California Environmental Protection Agency, Office of Environmental Health Hazard Assessment, 2005.

Centers for Disease Control and Prevention. *Third National Report on Human Exposure to Environmental Chemicals.* Atlanta: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Environmental Health, 2005. NCEH Publication No. 05-0570.

Copas JB, Shi JQ. Reanalysis of epidemiological evidence on lung cancer and passive smoking. *British Medical Journal* 2000;320(7232):417–8.

Coultas DB, Peake GT, Samet JM. Questionnaire assessment of lifetime and recent exposure to environmental tobacco smoke. *American Journal of Epidemiology* 1989;130(2):338–47.

Diethelm PA, Rielle JC, McKee M. The whole truth and nothing but the truth? The research that Phillip Morris did not want you to see, November 11, 2004; <http://image.thelancet.com/extras/03art7306web.pdf>; accessed: January 6, 2005.

Emerson JA, Hovell MF, Meltzer SB, Zakarian JM, Hofstetter CR, Wahlgren DR, Leaderer BP, Meltzer EO. The accuracy of environmental tobacco smoke exposure measures among asthmatic children. *Journal of Clinical Epidemiology* 1995;48(10):1251–9.

Fleiss JL, Gross AJ. Meta-analysis in epidemiology, with special reference to studies of the association between exposure to environmental tobacco smoke and lung cancer: a critique. *Journal of Clinical Epidemiology* 1991;44(2):127–39.

Flue-Cured Tobacco Cooperative Stabilization Corp. v. United States Environmental Protection Agency (M.D.N.C. June 22, 1993), *cited in* 8.2 TPLR 3.97 (1993).

Flue-Cured Tobacco Cooperative Stabilization Corp. v. The United States Environmental Protection Agency, No. 98-2407 (4th Cir., December 11, 2002), *cited in* 17.7 TPLR 2.472 (2003) (Overturning lower court's decision invalidating EPA's findings that secondhand smoke is a "known human carcinogen").

Fontham ET, Correa P, Reynolds P, Wu-Williams A, Buffler PA, Greenberg RS, Chen VW, Alterman T, Boyd P, Austin DF, Liff J. Environmental tobacco smoke and lung cancer in nonsmoking women: a multicenter study. *Journal of the American Medical Association* 1994;271(22):1752–9.

Garne D, Watson M, Chapman S, Byrne F. Environmental tobacco smoke research published in the journal *Indoor and Built Environment* and associations with the tobacco industry. *Lancet* 2005; 365(9461):804–9.

Glantz SA. The ledger of tobacco control. *Journal of the American Medical Association* 1996;276(11):871–2.

Glantz SA. Lung cancer and passive smoking: nothing new was said. *British Medical Journal* 2000;321(7270):1222–3.

Hackshaw AK, Law MR, Wald NJ. The accumulated evidence on lung cancer and environmental tobacco smoke. *British Medical Journal* 1997;315(7114): 980–8.

Hammond SK, Leaderer BP. A diffusion monitor to measure exposure to passive smoking. *Environmental Science & Technology* 1987;21(5):494–7.

Hong MK, Bero LA. How the tobacco industry responded to an influential study of the health effects of secondhand smoke. *British Medical Journal* 2002;325(7377):1413–6.

International Agency for Research on Cancer. *IARC Monographs on the Evaluation of the Carcinogenic Risk of Chemicals to Humans: Tobacco Smoking.* Vol. 38. Lyon (France): International Agency for Research on Cancer, 1986.

International Agency for Research on Cancer. *IARC Monographs on the Evaluation of Carcinogenic Risks to Humans: Tobacco Smoke and Involuntary Smoking*. Vol. 83. Lyon (France): International Agency for Research on Cancer, 2004.

Jaakkola MS, Jaakkola JJ. Assessment of exposure to environmental tobacco smoke. *European Respiratory Journal* 1997;10(10):2384–97.

Jaakkola MS, Samet JM. Environmental tobacco smoke: risk assessment. *Environmental Health Perspectives* 1999;107(Suppl 6):823–904.

Kawachi I, Colditz GA. Invited commentary: confounding, measurement error, and publication bias in studies of passive smoking. *American Journal of Epidemiology* 1996;144(10):909–15.

Klepeis NE. An introduction to the indirect exposure assessment approach: modeling human exposure using microenvironmental measurements and the recent National Human Activity Pattern Survey. *Environmental Health Perspectives* 1999;107(Suppl 2):365–74.

Lee PN. Difficulties in assessing the relationship between passive smoking and lung cancer. *Statistical Methods in Medical Research* 1998;7(2):137–63.

Lee PN. Simple methods for checking for possible errors in reported odds ratios, relative risks and confidence intervals. *Statistics in Medicine* 1999;18(15):1973–81.

Lee PN, Forey BA. Misclassification of smoking habits as determined by cotinine or by repeated self-report—summary of evidence from 42 studies. *Journal of Smoking-Related Diseases* 1995;6:109–29.

Lee PN, Forey B, Fry JS. Revisiting the association between environmental tobacco smoke exposure and lung cancer risk. III: Adjusting for the biasing effect of misclassification of smoking habits. *Indoor and Built Environment* 2001;10(6):384–98.

Lubin JH. Estimating lung cancer risk with exposure to environmental tobacco smoke. *Environmental Health Perspectives* 1999;107(Suppl 6):879–83.

Matanoski G, Kanchanaraksa S, Lantry D, Chang Y. Characteristics of nonsmoking women in NHANES I and NHANES I Epidemiologic Follow-up Study with exposure to spouses who smoke. *American Journal of Epidemiology* 1995;142(2):149–57.

Misakian AL, Bero LA. Publication bias and research on passive smoking: comparison of published and unpublished studies. *Journal of the American Medical Association* 1998;280(3):250–3.

Morabia A, Bernstein MS, Bouchardy I, Kurtz J, Morris MA. Breast cancer and active and passive smoking: the role of the *N*-acetyltransferase 2 genotype. *American Journal of Epidemiology* 2000;152(3): 226–32.

National Health and Medical Research Council. *The Health Effects of Passive Smoking*. A scientific information paper. Canberra (Commonwealth of Australia): Canberra ACT, 1997.

National Research Council. *Environmental Tobacco Smoke: Measuring Exposures and Assessing Health Effects*. Washington: National Academy Press, 1986.

National Research Council. *Human Exposure Assessment for Airborne Pollutants: Advances and Opportunities*. Washington: National Academy Press, 1991.

Ong EK, Glantz SA. Tobacco industry efforts subverting International Agency for Research on Cancer's second-hand smoke study. *Lancet* 2000; 355(9211):1253–9.

Ong EK, Glantz SA. Constructing "sound science" and "good epidemiology": tobacco, lawyers, and public relations firms. *American Journal of Public Health* 2001;91(11):1749–57.

Pron GE, Burch JD, Howe GR, Miller AB. The reliability of passive smoking histories reported in a case-control study of lung cancer. *American Journal of Epidemiology* 1988;127(2):267–73.

Rampton S, Stauber J. *Trust Us, We're Experts: How Industry Manipulates Science and Gambles with Your Future*. Los Angeles: J.P. Tarcher, 2000.

Rothman KJ, Greenland S. *Modern Epidemiology*, 2nd ed. Philadelphia: Lippincott-Raven, 1998.

Samet JM, Jaakkola JJK. The epidemiologic approach to investigating outdoor air pollution. In: Holgate ST, Samet JM, Koren HS, Maynard RL, editors. *Air Pollution and Health*. San Diego: Academic Press, 1999:431–60.

Scientific Committee on Tobacco and Health. *Report of the Scientific Committee on Tobacco and Health*. London: The Stationery Office, 1998.

Thornton A, Lee P, Fry J. Differences between smokers, ex-smokers, passive smokers and non-smokers. *Journal of Clinical Epidemiology* 1994;47(10):1143–62.

Thun M, Henley J, Apicella L. Epidemiologic studies of fatal and nonfatal cardiovascular disease and ETS exposure from spousal smoking. *Environmental Health Perspectives* 1999;107(Suppl 6):841–6.

Tweedie RL, Mengersen KL. Meta-analytic approaches to dose-response relationships, with application in studies of lung cancer and exposure to environmental tobacco smoke. *Statistics in Medicine* 1995; 14(5–7):545–69.

U.S. Department of Health and Human Services. *The Health Consequences of Smoking: Cancer. A Report of the Surgeon General.* Rockville (MD): U.S. Department of Health and Human Services, Public Health Service, Office on Smoking and Health. 1982. DHHS Publication No. (PHS) 82-50179.

U.S. Department of Health and Human Services. *The Health Consequences of Smoking: Chronic Obstructive Lung Disease. A Report of the Surgeon General.* Rockville (MD): U.S. Department of Health and Human Services, Public Health Service, Office on Smoking and Health, 1984. DHHS Publication No. (PHS) 84-50205.

U.S. Department of Health and Human Services. *The Health Consequences of Involuntary Smoking. A Report of the Surgeon General.* Rockville (MD): U.S. Department of Health and Human Services, Public Health Service, Centers for Disease Control, Center for Health Promotion and Education, Office on Smoking and Health, 1986. DHHS Publication No. (CDC) 87-8398.

U.S. Department of Health and Human Services. *Preventing Tobacco Use Among Young People. A Report of the Surgeon General.* Atlanta: U.S. Department of Health and Human Services, Public Health Service, Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health, 1994.

U.S. Department of Health and Human Services. *Tobacco Use Among U.S. Racial/Ethnic Minority Groups—African Americans, American Indians and Alaska Natives, Asian Americans and Pacific Islanders, and Hispanics. A Report of the Surgeon General.* Atlanta: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health, 1998.

U.S. Department of Health and Human Services. *Healthy People 2010: Understanding and Improving Health.* Washington: U.S. Government Printing Office, 2000.

U.S. Department of Health and Human Services. *Women and Smoking. A Report of the Surgeon General.* Rockville (MD): U.S. Department of Health and Human Services, Public Health Service, Office of the Surgeon General, 2001.

U.S. Department of Health and Human Services. *The Health Consequences of Smoking: A Report of the Surgeon General.* Atlanta: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health, 2004.

U.S. Department of Health, Education, and Welfare. *Smoking and Health: Report of the Advisory Committee to the Surgeon General of the Public Health Service.* Washington: U.S. Department of Health, Education, and Welfare, Public Health Service, Center for Disease Control, 1964. PHS Publication No. 1103.

U.S. Department of Health, Education, and Welfare. *The Health Consequences of Smoking. A Report of the Surgeon General: 1972.* Washington: U.S. Department of Health, Education, and Welfare, Public Health Service, Health Services and Mental Health Administration, 1972. DHEW Publication No. (HSM) 72-7516.

U.S. Department of Health, Education, and Welfare. *The Health Consequences of Smoking. A Report of the Surgeon General, 1975.* Washington: U.S. Department of Health, Education, and Welfare, Public Health Service, Center for Disease Control, 1975. DHEW Publication No. (CDC) 77-8704.

U.S. Department of Health, Education, and Welfare. *Smoking and Health. A Report of the Surgeon General.* Washington: U.S. Department of Health, Education, and Welfare, Public Health Service, Office of the Assistant Secretary for Health, Office of Smoking and Health, 1979. DHEW Publication No. (PHS) 79-50066.

U.S. Environmental Protection Agency. *Respiratory Health Effects of Passive Smoking: Lung Cancer and Other Disorders.* Washington: U.S. Environmental Protection Agency, Office of Research and Development, Office of Air Radiation, 1992. Report No. EPA/600/6-90/0006F.

Vandenbroucke JP. Passive smoking and lung cancer: a publication bias? *British Medical Journal (Clinical Research Edition)* 1988;296(6619):391–2.

Wald NJ, Nanchahal K, Thompson SG, Cuckle HS. Does breathing other people's tobacco smoke cause lung cancer? *British Medical Journal (Clinical Research Edition)* 1986;293(6556):1217–22.

World Health Organization. *International Consultation on Environmental Tobacco Smoke (ETS) and Child Health. Consultation Report.* Geneva: World Health Organization, 1999.

Wu AH. Exposure misclassification bias in studies of environmental tobacco smoke and lung cancer. *Environmental Health Perspectives* 1999;107(Suppl 6):873–7.

Yach D, Bialous SA. Junking science to promote tobacco. *American Journal of Public Health* 2001;91(11):1745–8.

TESTIMONY IN SUPPORT OF INT. NO. 332 PROHIBITING SMOKING IN PEDESTRIAN PLAZAS AND PUBLIC PARKS AND BEACHES

By: Claire Millman
President, Alliance For Smoke-Free Air
(516) 433 8278

October 15, 2010

I am Claire Millman, President of the Alliance For Smoke-Free Air and have been actively involved in this prominent health issue for 37 plus years. I made the initial appeal for and subsequent strengthening of all tobacco control legislation in Suffolk, Nassau, New York City and New York State and have, therefore, heard all the opposition arguments and watched them proven invalid as smoke-free has become, justifiably, the norm in many venues of our environment.

What has changed since the last strengthening in New York City? Substantially increased mountain of scientific evidence from studies worldwide re the disease and death caused by second hand smoke, including the variety of other cancers in addition to lung cancer, the much larger incidence of fatal heart attacks than previously known and the fact that even short term exposure to second hand smoke adversely affects the public. The now chronicled numerous studies verifying the harmful effects of exposure to second hand smoke outdoors, as called out in the intent of this bill support its passage, and the public support, as a result of the continued suffering due to exposure outdoors to this carcinogenic and toxic contaminant, and the increased knowledge all verify the necessity for enacting this bill into law.

There is no safe level of exposure to second hand smoke, a Class A carcinogen. The presence, use and proliferation of a toxic and carcinogenic product in public places is detrimental to the health, safety and welfare of all our residents of all ages. No other scourge of this magnitude is permitted to exist in public places, if the remedy

is known. Smokefree protects against disease, saves lives and costs nothing.

Many nonsmokers exposed to outdoor tobacco smoke suffer immediate symptoms including breathing difficulties, outright asthma attacks, nausea, irritations of the eyes and throat which progress to infection, serious respiratory conditions, and heart and lung disease. In addition to the necessary protection from second hand smoke, there is the importance of preventing small children from ingesting the cigarette butts and/or choking on them, and the importance of positive role model for children and youth (these restrictions denormalize smoking, thereby discouraging the youth from starting).

Cigarette butts, which are not biodegradable, constitute a tremendous and unhealthy litter problem.

Scientific evidence is effective only in its application. There is substantial precedent in many places in our country and throughout the world for this legislation, and the number is growing rapidly. The feedback from these localities verifies that these laws are self-enforcing, because most people are law abiding and the prominently displayed “no smoking” signs are obeyed.

Laws mandating smokefree places are a major factor in reducing social acceptability of smoking, benefiting all our society. While protecting the health and safety of nonsmokers, they provide incentives for smokers to quit and send a message to all that active and passive smoking kill.

We commend New York City for its ongoing leadership action on behalf of the health, safety and welfare of our people, and look forward to the passage of the strongest version of this bill.

Note: In 2002 I appealed to the Board of the Town of Oyster Bay, Long Island, N.Y. for a law banning smoking in all playgrounds, parks and beaches. I supplied the members of the Town Board with factual information in support of such a law, and worked with the Board to formulate the actual bill. The resulting law was passed in December, 2002, and in March, 2003 I was honored with the title of Woman of Distinction 2003 Town of Oyster Bay.

From: "joe boone" <j1o2ey@yahoo.com>
Date: 10/16/2010 7:54:44 AM
To: "speakerquinn@council.nyc.gov" <speakerquinn@council.nyc.gov>
Cc: "brewer@council.nyc.ny.us" <brewer@council.nyc.ny.us>,
"brewer@council.nyc.gov" <brewer@council.nyc.gov>
Subject: Re: NYC Council Smoking Ban Hearing

Dear Speaker Quinn and Council Member Brewer,

Due to unforseen cicumstances, I was unable to attend the public hearing on Intro. 332 last Thursday, Oct 14th. Please accept my apology. My absence at the hearing has in no way diluted my support for the ban on smoking in public parks and pedestrian plazas.
I am garnering increasing support for Intro 332 with my family and friends, colleagues at work (over 2000), PTA group (about 40 parents) and my co-op building
(96 residences). We fully stand behind you on this issue and look forward to attending any future hearings to testify in support of this proposed legislation. Please keep me informed of any and all future dates when similar public hearings will take place.
Additionally, please utilize any portion of my (intended) statement (see below), which I prepared to deliver at the hearing, in any future justifications for the passing of your important bill. Thank you, Joe Boone

Statement for Healthier NY hearing; Point,Example,Point Outline:

POINT: Second hand smoke and used cigarette filters damages both the environment and the health of non smokers, especially our innocent children.
I hope this bill to ban smoking in all public parks and pedestrian plazas is only a beginning that leads to a full ban on smoking in all NYC public sidewalks as well.
Tobacco smoke contains over 4,000 different chemicals. Over 40 are known to cause cancer in humans.
a. Formaldehyde (embalming fluid)
used to preserve dead bodies
b. Arsenic (rat poison),
c. Hydrogen Cyanide (gas chamber poison)
d. Polonium-210- highly radioactive material used to kill Russian ex-spy Alexander Litvinenko in 2006
EXAMPLES:
Plaza near Bleeker Park: Adjacent to childrenâ€™s park, often smell (inhale) tobacco smoke from smokers
Horatio & Hudson Park- often many Adults smoking Cigarettes.
Hudson River - Christopher St Piers- Avoid it w/ son altogether because of all cigarette smoke. Other parents have told me same.
POINT: Each year, smokers worldwide deposit 4.5 trillion cigarette butts.
That's over 8 million every minute.
That's so many that if you stacked them on top of each other, end to end, they would stretch to the moon and back - 150 times.
Here in the U.S. , more than 1.35 trillion cigarettes were manufactured in 2007, of which

360 billion were smoked here. Look closely at the ground at any intersection. They're everywhere!

The butts flicked onto the sidewalk or street find their way into storm drains, many of them washing into our waterways.

Cigarette butts are made of a bundle of 12,000 plastic-like cellulose acetate fibers, a form of plastic, which can take up to 12 years to break down, and when in contact with water can leach chemicals such as cadmium, lead and arsenic, ultimately potentially polluting our marine environment. Are cigarette butts litter? Absolutely! But unlike paper products they're not biodegradable.

The nicotine trapped inside 200 used filters is likely sufficient to kill a 160 pound adult human - 50 to 60 milligrams.

Tar refers to those 4000 chemicals with 50 cancer causing poisons that include arsenic, vinyl chloride, acetone, mercury and lead. Modern filters trap roughly half the tar while capturing one-third of a cigaretteâ€™s formaldehyde and two-thirds of its hydrogen cyanide. Pick up a few dozen butts and take a big whiff. Smell the scent of bitter almonds? Thatâ€™s hydrogen cyanide. (Hold up and show everyone ziplock bag with all used cigarette butts collected from Bleeker park plaza Saturday afternoon)

Because of 4000 chemicals in cig smoke, including over 40 known carcinogens, that damage human health, I encourage the city council to do whatâ€™s best for this city and the Great State of NY and make the passing of this legislation to ban smoking in all city parks and ped plazas your top priority.

Thank you for allowing me this opportunity to speak before you here today.

Matt Shotkin

Smoking cessation in the beaches and parks can be a problem:

With the price of cigarettes going up, and less people smoking, it might be less or More of a problem: I'm not really sure which:

Maybe, a compromise of a smoking ban in the larger parks: For example Central And Bryant Park:

There are trainings for smoking cessation: Cigarette litter accounts for 75 Per_cent of the cities litter:

I also propose a smoking ban in the bars and clubs, because smoking there is just A bad habit for folks: A friend of mine has lives at 251 E 84th Street, and Has a bar"s big Ashtray right under a door: More bad news:

I think there should also be a ban on Penthouse and roof smoking as well:

Some people currently smoke on rooftops of Apartment buildings:

I want to thank you for this opportunity to testify on this very critical issue:

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. 332 Res. No. _____

☒ in favor ☐ in opposition

Date: 10/14/10

(PLEASE PRINT)

Name: William Borden, MD

Address: 1305 York Ave, NY NY 10021

I represent: American Heart Association

Address: 122 E. 42nd St., 18th Flr, NY NY 10168

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. _____ Res. No. _____

☐ in favor ☒ in opposition

Date: 10/14/10

(PLEASE PRINT)

Name: Lisa DeFrancesco

Address: 2754 Coney Island Ave #57

I represent: _____

Address: _____

Please complete this card and return to the Sergeant-at-Arms

THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. _____ Res. No. _____

☒ in favor ☐ in opposition

Date: 10/15/2010

(PLEASE PRINT)

Name: Georgett

Address: 76-10. 34 Ave

I represent: Smoke Free

Address: Jackson Hgts-NY

Please complete this card and return to the Sergeant-at-Arms

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. 332 Res. No. _____

☒ in favor ☐ in opposition

Date: _____

(PLEASE PRINT)

Name: Darrin Johnson

Address: _____

I represent: NY Restoration Project (NYRP)

Address: _____

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. 332 Res. No. _____

☒ in favor ☐ in opposition

Date: 10.14.10

(PLEASE PRINT)

Name: Lauren Schuster

Address: 225 Byrne Ave SI NY 10314

I represent: NYPIRG

Address: 9 Murray St Fl. 3. NY NY 10009

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. _____ Res. No. _____

☐ in favor ☐ in opposition

Date: _____

(PLEASE PRINT)

Name: [illegible]

Address: [illegible]

I represent: [illegible]

Address: [illegible]

Please complete this card and return to the Sergeant-at-Arms

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. _____ Res. No. 332-2010

☑ in favor ☐ in opposition

Date: October 14, 2010

(PLEASE PRINT)

Name: Barbara Hart

Address: 300 C W. 137th St., N.Y., N.Y. 10030

I represent: BRONX BREATHES

Address: 1300 Morris Park Avenue, Bx, N.Y. 10461
Mazer Hall - Room 106

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. 332 Res. No. _____

☑ in favor ☐ in opposition

Date: 10/14/10

(PLEASE PRINT)

Name: Gladys Rivera

Address: _____

I represent: Hale Hir. Road NY

Address: 301 Grove St. Brooklyn NY

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. 332 Res. No. _____

☑ in favor ☐ in opposition

Date: 10/14/10

(PLEASE PRINT)

Name: Hilary Klein

Address: 301 Grove St Brooklyn NY

I represent: Hale Hir Road NY

Address: 301 Grove St. Brooklyn NY

Please complete this card and return to the Sergeant-at-Arms

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. 332 Res. No. _____

☑ in favor ☐ in opposition

Date: 10/14/10

(PLEASE PRINT)

Name: MARIAE Kochiche

Address: 1351 HANCOCK ST B'KLYN NY 11237

I represent: MRNY

Address: 301 Grove st B'KLYN NY 11237

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. _____ Res. No. _____

☐ in favor ☑ in opposition

Date: 10.14.10

(PLEASE PRINT)

Name: Stephen Helfer

Address: 3 CRAWFORD ST #8 CAMB. MA

I represent: NYC CLASH

Address: Brooklyn NY

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. _____ Res. No. _____

☑ in favor ☐ in opposition

Date: 10/14

(PLEASE PRINT)

Name: HASAN RAZA

Address: 1081- Coney Island Ave Bklyn

I represent: Council of Peoples org

Address: _____

Please complete this card and return to the Sergeant-at-Arms

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. 332 Res. No. _____

☒ in favor ☐ in opposition

Date: 10/14/10

(PLEASE PRINT)

Name: Ted Ryo

Address: 6113 CAY Plaza

I represent: Korean Community Services

Address: _____

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. 332 Res. No. _____

☒ in favor ☐ in opposition

Date: 10/14/10

(PLEASE PRINT)

Name: Karen Blumenfeld, Esq., Global Advisors on Smokefree Policy

Address: Summit, NJ

I represent: Global Advisors on Smokefree Policy

Address: Summit NJ

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. 332 Res. No. _____

☒ in favor ☐ in opposition

Date: 10/14/10

(PLEASE PRINT)

Name: Phil Konigsberg

Address: 23-25 Bell BLVD Bay Terrace NY

I represent: FOFTP BTCA - Individual

Address: Bay Terrace NY 11360

Please complete this card and return to the Sergeant-at-Arms

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. _____ Res. No. _____

☐ in favor ☐ in opposition

Date: _____

(PLEASE PRINT)

Name: Haribai Pashi

Address: E 105th Cone, Isl. Ave

I represent: COPO

Address: _____

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. 332 Res. No. _____

☒ in favor ☐ in opposition

Date: 10/14/10

(PLEASE PRINT)

Name: Douglas Le

Address: _____

I represent: Asian Americans for Equality

Address: 108 Norfolk St, NY NY 10002

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. 332 Res. No. _____

☒ in favor ☐ in opposition

Date: 10/14/10

(PLEASE PRINT)

Name: José González

Address: 939 Woodycrest Ave

I represent: Highbridge - Smoke-Free Public Parks & Beaches

Address: Smoke Free - Sparks

Please complete this card and return to the Sergeant-at-Arms

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. _____ Res. No. _____

☑ in favor ☐ in opposition

Date: _____

(PLEASE PRINT)

Name: Wayne Graves

Address: 52-40 39 Dr.

I represent: The Lesbian, Gay, Bisexual & Transgender Community Center

Address: 208 West 13th Street

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. 332 Res. No. _____

☑ in favor ☐ in opposition

Date: _____

(PLEASE PRINT)

Name: James Pistilli

Address: 5414 Arthur Kill Rd

I represent: SI Greenbelt - Conference House Park

Address: Conservancy - Tottenville Civic

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. 332 Res. No. _____

☐ in favor ■ in opposition

Date: _____

(PLEASE PRINT)

Name: Matthias Clock

Address: 200 Water Street

I represent: _____

Address: _____

Please complete this card and return to the Sergeant-at-Arms

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. 332 Res. No. _____

☒ in favor ☐ in opposition

Date: 10/14/10

(PLEASE PRINT)

Name: Michael Seilback

Address: 116 John ST, 30TH Floor

I represent: American Lung Association in NY

Address: _____

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. 332 Res. No. _____

☒ in favor ☐ in opposition

Date: _____

(PLEASE PRINT)

Name: Maureen Killacky MD

Address: _____

I represent: American Lung Association

Address: 1275 York Avenue

NYC 10065

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. 332 Res. No. _____

☒ in favor ☐ in opposition

Date: 10-14-2010

(PLEASE PRINT)

Name: WARREN SCHREIBER

Address: 13-24 BELL BLVD, BAYSIDE, 11360

I represent: BAY TERRACE COMMUNITY ALLIANCE

Address: _____

Please complete this card and return to the Sergeant-at-Arms

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. 332 Res. No. _____

☑ in favor ☐ in opposition

Date: 10.14.10

(PLEASE PRINT)

Name: Sheelah Feinberg

Address: 120 Wall St.

I represent: NYC Coalition for a Smoke free City

Address: 100 Wall St. 25th Floor

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. _____ Res. No. 332

☐ in favor ☑ in opposition

Date: _____

(PLEASE PRINT)

Name: Margaret Waldman

Address: 110 Fulton St #3B, NY, NY 10038

I represent: Self (c.l.a.s.h.)

Address:

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. _____ Res. No. _____

☐ in favor ☑ in opposition

Date: _____

(PLEASE PRINT)

Name: INGRID ANN ZACEK

Address: 405 E. 92 Street 1K

I represent: Smoker's rights

Address: and proof

Please complete this card and return to the Sergeant-at-Arms

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. _____ Res. No. _____

☐ in favor ☑ in opposition

Date: 10/14/10

(PLEASE PRINT)

Name: BARBARA FISCHER

Address: 135 SEGUINE AV, S.I. NY. 10309

I represent: NYC CLASH.

Address: BKLYN, NY 11234

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. _____ Res. No. _____

☐ in favor ☐ in opposition

Date: _____

(PLEASE PRINT)

Name: Geoffrey Croft

Address: _____

I represent: NYC PARK ADVOCATES

Address: _____

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. _____ Res. No. _____

☑ in favor ☐ in opposition

Date: 10/13/2010

(PLEASE PRINT)

Name: Irv Kaplan

Address: 102-30 67th Ave

I represent: _____

Address: _____

Please complete this card and return to the Sergeant-at-Arms

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. 332 Res. No. _____

☐ in favor ☒ in opposition

Date: _____

(PLEASE PRINT)

Name: JOE ROWE

Address: 4 BRADLEY PARK CT COLUMBUS GA

I represent: IPCPR

Address: 4 BRADLEY PARK Ct. "

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. _____ Res. No. _____

☑ in favor ☐ in opposition

Date: 10/14/10

(PLEASE PRINT)

Name: Laila Modzelewski

Address: 109 Lafayette Ave S.I. NY 10301

I represent: Take Care Staten Island

Address: 51 Stuyvesant Pl Staten Is. NY

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. _____ Res. No. _____

☐ in favor ☒ in opposition

but requesting a waiver for theatre. *Date:* 10/14/10

(PLEASE PRINT)

Name: Laurie Baskin

Address: 520 8th Ave NYC

I represent: Theatre Communications Group

Address: 520 8th Ave NY, NY

Please complete this card and return to the Sergeant-at-Arms

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. _____ Res. No. 332

☐ in favor ☑ in opposition

Date: _____

(PLEASE PRINT)

Name: WAYNE MONES

Address: 226 GRASMERE DR SI NY 10305

I represent: SILF

Address: _____

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. 332 Res. No. _____

☑ in favor ☐ in opposition

Date: 10/14/10

(PLEASE PRINT)

Name: Beverly Nelson

Address: 1775 Walton Ave #9G

I represent: Highbridge Comm Life Center

Address: 979 Ogden Ave Bx NY 10452

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. 332 Res. No. _____

☑ in favor ☐ in opposition

Date: _____

(PLEASE PRINT)

Name: Lisette Lopez

Address: 44 Ontario Avenue Middletown, NY 10940

I represent: Highbridge Community Life Center

Address: 979 Ogden Avenue.

Please complete this card and return to the Sergeant-at-Arms

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. 332 Res. No. _____

☐ in favor ☑ in opposition

Date: 10/14/2010

(PLEASE PRINT)

Name: Colin Pelle.

Address: 391 E 168 STREET

I represent: Solaro GED Program

Address: 555 Bergent Ave. 149 Street

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. _____ Res. No. _____

☒ in favor ☐ in opposition

Date: _____

(PLEASE PRINT)

Name: Dr. Thomas Farley

Address: Commissioner

I represent: Department of Health & Mental Hygiene

Address: _____

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. _____ Res. No. _____

☒ in favor ☐ in opposition

Date: _____

(PLEASE PRINT)

Name: Adrian Benepe

Address: Commissioner

I represent: Department of Parks & Recreation

Address: _____

Please complete this card and return to the Sergeant-at-Arms

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. 332 Res. No. ____

☐ in favor ☒ in opposition

Date: 10-14-2010

(PLEASE PRINT)

Name: GLYNN COPE

Address: ____

I represent: Cigar Rights of America

Address: ____

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. 332 Res. No. ____

☐ in favor ☒ in opposition

Date: 10/14/2010

(PLEASE PRINT)

Name: Ron Melnick

Address: 1390 6th Ave NY NY 10019

I represent: New York Tobacconists Assoc.

Address: 1390 6th Ave NY NY 10019.

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. 332 Res. No. ____

~~☐ in favor~~ ☒ in opposition

Date: OCT. 14 2010

(PLEASE PRINT)

Name: Leonard Waller

Address: 3021 Briggs Ave. Bronx NY 10458

I represent: CLASH & CRA

Address: P.O. Box 1036 Bklyn NY. 11234

Please complete this card and return to the Sergeant-at-Arms

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. 332 Res. No. _____

☑ in favor ☐ in opposition

Date: 10/14/10

(PLEASE PRINT)

Name: JOE APPELBAUM

Address: 2555 E 12th ST - 4F BKLYN 11235

I represent: _____

Address: _____

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. 332 Res. No. _____

☑ in favor ☐ in opposition

Date: _____

(PLEASE PRINT)

Name: NATHALIE WEEKS

Address: 689 FT. WASHINGTON AVE 10040

I represent: STATEN ISLAND MENTAL HEALTH SOC.

Address: 669 CASTLETON AVE. S.I. 10301

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. 332 Res. No. _____

☐ in favor ☒ in opposition

Date: 10.14.10

(PLEASE PRINT)

Name: HOWARD C. YEROX

Address: 411 AVE A NYC 10021

I represent: GOLF

Address: SOME 95 GROVE

Please complete this card and return to the Sergeant-at-Arms

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. 332 Res. No. _____

☐ in favor ☒ in opposition

Date: 10/14/10

(PLEASE PRINT)

Name: DAVID GOERLITZ

Address: 29 W. FACTORY RD

I represent: NYC CLASH

Address: P.O BOX 1136, BROOKLYN N.Y.

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. 332 Res. No. _____

☐ in favor ☒ in opposition

Date: 10/14/10

(PLEASE PRINT)

Name: LINDA STEWART

Address: NYC CLASH PO Box 1136 Bklyn

I represent: NYC CLASH

Address: 301 E 66th St

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. 332 Res. No. _____

☐ in favor ☒ in opposition

Date: 10/14/10

(PLEASE PRINT)

Name: Audrey Silk (NYC C.L.A.S.H)

Address: P.O. Box 1036 Brooklyn, NY 11234

I represent: NYC C.L.A.S.H.

Address: S/A/A

Please complete this card and return to the Sergeant-at-Arms

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. 332 Res. No. _____

☒ in favor ☐ in opposition

Date: Oct 14, 2010

(PLEASE PRINT)

Name: Darin E. Johnson New York Restoration Project

Address: 254 W 31st Street 10th fl

I represent: New York Restoration Project

Address: same as above

Please complete this card and return to the Sergeant-at-Arms

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. _____ Res. No. _____

☐ in favor ☒ in opposition

Date: 10/14

(PLEASE PRINT)

Name: John Davis

Address: _____

I represent: Self

Address: _____

Please complete this card and return to the Sergeant-at-Arms