WEST VIRGINIA
SECRETARY OF STATE
KEN HECHLER
ADMINISTRATIVE LAW DIVISION

Form #7

Do Not Mark In this Box

FILED
1990 DEC 26 PM 1:45
OFFICE OF WEST VIRGINIA
SECRETARY OF STATE

NOTICE OF AN EMERGENCY RULE

AGENCY: Department of Administration TITLE NUMBER: 148

CITE AUTHORITY: WV Code 5A-4-2, 5A-3-42

EMERGENCY AMENDMENT TO AN EXISTING RULE: YES____, NO X

IF YES, SERIES NUMBER OF RULE BEING AMENDED: _____

TITLE OF RULE BEING AMENDED: _____

IF NO, SERIES NUMBER OF RULE BEING FILED AS AN EMERGENCY: Series 7

TITLE OF RULE BEING FILED AS AN EMERGENCY: Smoking Restriction Guidelines for West Virginia State Buildings

THE ABOVE RULE IS BEING FILED AS AN EMERGENCY RULE TO BECOME EFFECTIVE UPON FILING.

THE FACTS AND CIRCUMSTANCES CONSTITUTING THE EMERGENCY ARE AS FOLLOWS:

The working environment of State employees should present no unnecessary risk of physical harm or discomfort from environmental tobacco smoke which is a known cause of lung cancer.

As an employer with the responsibility to provide a safe and healthful work environment free from recognized and avoidable hazards, it is in the public interest for the Department of Administration, as the custodial agent for State owned, rented, leased facilities, to direct that a smoke free environment be assured not only for each State employee, but for the public as well, as they transact business with or receive services from the State.

Use Additional Sheets If Necessary.

C W Fox

2.90

STATE OF WEST VIRGINIA
DEPARTMENT OF ADMINISTRATION
State Capitol
Charleston, WV 25305

Gaston Caperton
Governor

Chuck Polan
Secretary

December 20, 1990

Honorable Ken Hechler
Secretary of State
Suite 157-K
Capitol Building
Charleston, WV 25305

Re: Emergency Rules for Smoking Restrictions

Dear Mr. Hechler:

Approval is hereby given for filing of emergency rules of the Department of Administration entitled "Smoking Restriction Guidelines for West Virginia State Buildings", as enclosed, in accordance with West Virginia Code, 5A-4-2, 5A-3-42.

Sincerely,

Chuck Polan
Secretary

CP:ah

Attachment

DATE: December 20, 1990

TO: LEGISLATIVE RULE-MAKING REVIEW COMMITTEE

FROM: Department of Administration

EMERGENCY RULE TITLE: Smoking Restriction Guidelines for West Virginia State Buildings

1. Date of filing: December 20, 1990

2. Statutory authority for promulgating the emergency rule: WV Code 5A-4-2, 5A-3-42

3. Date of filing of proposed legislative rule: 12-20-90

4. Does the emergency rule adopt new language or does it amend or repeal a current legislative rule?

No

5. Has the same or similar emergency rule previously been filed and expired?

No

6. State, with particularity, those facts and circumstances which make the emergency rule necessary for the immediate preservation of public peace, health, safety or welfare.

To immediately provide a smoke-free environment for employees and the public as they visit the state buildings

7. If the emergency rule was promulgated in order to comply with a time limit established by the Code or federal statute or regulation, cite the Code provision, federal statute or regulation and time limit established therein.

N/A

8. State, with particularity, those facts and circumstances which make the emergency rule necessary to prevent substantial harm to the public interest.

Tobacco smoke is known to cause lung cancer, thus a smokefree environment will reduce the harm to the public

APPENDIX B

FISCAL NOTE FOR PROPOSED RULES

Rule Title: Smoking Restriction Guidelines for West Virginia State Buildings

Type of Rule: XX Legislative _____ Interpretive _____ Procedural

Agency: Department of Administration Address _____

1. Effect of Proposed Rule	ANNUAL Increase	ANNUAL Decrease	FISCAL YEAR Current	FISCAL YEAR Next	FISCAL YEAR Thereafter
Estimated Total Cost	$	$	$	$	$
Personal Services					
Current Expense					
Repairs and Alterations					
Equipment					
Other					

2. Explanation of above estimates: No additional costs are anticipated by implementing these rules

3. Objectives of these rules: To provide a smokefree environment for employees and the public as they visit state buildings

4. Explanation of Overall Economic Impact of Proposed Rule.

A. Economic Impact on State Government. None

B. Economic Impact on Political Subdivisions; Specific Industries; Specific groups of citizens. None

C. Economic Impact on Citizens/Public at Large. None

Date: _____

Signature of Agency Head or Authorized Representative

_____

148 CSR 7

TITLE 148
LEGISLATIVE RULES
DEPARTMENT OF ADMINISTRATION

SERIES 7

SMOKING PROCEDURES

Section 148-7-1. General

1.1 Scope.--The purpose of this rule is to establish procedures to ensure a healthful, smoke-free environment for each State employee and the public as they transact business with or receive service from the State in buildings, offices or other space, motor vehicles and aircraft owned or leased by the State and under the control of the Department of Administration. This rule does not apply to the offices and areas of the West Virginia Supreme Court of Appeals, the Legislature or constitutional officers.

1.2 Authority.--West Virginia Code 5A-4-1, 5A-4-2, 5A-3-42, and 5-3-48.

1.3 Filing Date.--December 19, 1990.

1.4 Effective Date.--

Section 148-7-2. Definitions

2.1 Appointing Authority: An agency head or his/her designee, such as agency supervisors, section or unit heads, or other individuals designated by the agency head.

2.2 Cigarette: Any lighted tobacco product.

2.3 ETS: Environmental tobacco smoke; secondhand or sidestream smoke.

2.4 Proper Ventilation: Smoke exhausted to the outside. The system used to expel the smoke shall not diminish the working conditions of the employees' environment; for example, the method may not affect the building's heating and cooling system.

2.5 Workplace/Worksite: Any office, facility, building, etc., owned or operated by the State covered by this rule,

including State-owned/leased motor vehicles and aircraft.

Section 148-7-3. Applicability

This rule is applicable to buildings, offices, other space, motor vehicles and aircraft owned or leased by the State and under the control of the Department of Administration. This rule does not apply to the offices and areas of the West Virginia Supreme Court of Appeals, Legislature or constitutional officers. State facilities such as hospitals, mental hospitals, prisons and/or regional jails shall comply with this rule to the maximum extent possible. The only exceptions will be by the express mutual approval of the affected appointing authority and the Secretary of the Department of Administration. All exceptions will be made with public health and safety being the prime consideration.

Section 148-7-4. Procedures

4.1 It shall be the responsibility of the appointing authority to ensure that all workplaces maintain a healthful, smoke-free environment and to make both employees and the public aware of their responsibility to comply with the smoking restrictions.

(a) Appointing authorities shall establish a smoke-free environment in State workplaces.

(b) Appointing authorities must prohibit smoking in worksites for employees and the public if accommodations cannot be made without exposing individuals to the effects of secondhand or sidestream smoke.

(c) Appointing authorities may make reasonable accommodations for smokers, wherever possible and whenever practical, as follows:

(1) Appointing authorities may establish smoking areas at worksites, as long as the areas are properly ventilated and/or employees and the public have a smoke-free environment with no material effects from secondhand or sidestream smoke.

(2) Appointing authorities are not required to make special accommodations for individual smoking areas, but may do so in accordance with this section.

(d) In the application of this rule, anytime there is a conflict between the rights of smokers and non-smokers, the rights of non-smokers shall prevail.

4.2 Public waiting rooms and receiving areas shall be smoke-free, and smoking restrictions shall be actively enforced by the individuals responsible for those areas.

(a) The appointing authority shall post signs, worded as specifically as possible, designating smoking and non-smoking areas, if smoking areas exist.

(b) Receptacles should be placed outside all buildings to encourage persons to extinguish smoking products before entering, and an overview of the agency's smoking restriction policy should be posted in all waiting rooms and reception areas.

(c) The agency shall incur all reasonable costs of the signs, receptacles, etc., and their installation.

4.3 Smoking restrictions shall be enforced at all conferences, meetings, and training sessions conducted by the State and shall be consistent with all other provisions of this rule. All non-State entities using State workplaces must conform to this rule.

4.4 Appointing authorities are encouraged to provide support and assistance to employees and the public in the implementation and enforcement of this rule.

4.5 All related policies shall be enforced by the appointing authorities.

(a) This rule does not supersede any local ordinances or State statutes that are more restrictive and applicable, nor does it permit discrimination against smokers applying for positions.

(b) While employers do have the right to make rules for their own premises, employers may not prohibit lawful behavior and the use of lawful tobacco products outside the site of the workplace under this rule.

FILED

1991 JAN -4 AM 9:41

OFFICE OF WEST VIRGINIA
SECRETARY OF STATE

P.O. Box 812
Charleston, WV 25323
January 2, 1991

Honorable Ken Hechler
Secretary of State
Suite 157-K
Capitol Building
Charleston, WV 25305

Re: Emergency Rules For Smoking Restrictions

Dear Mr. Hechler:

We, the undersigned, request that you take immediate action to disapprove the Emergency Rules for Smoking Restrictions filed by the Department of Administration on December 26, 1990.

We request this action because the Secretary of Administration has clearly exceeded the scope of his statutory authority as referred to in Section 148-7-1.2 of this Emergency Rule. West Virginia Code Sections 5A-4-1 and 5A-4-2 give custodial authority over the capitol buildings and grounds. Only by the wildest stretch of the imagination do such duties include air pollution and in any event do not pertain to the building of the Public Service Commission. West Virginia Code Section 5A-3-42 gives the Secretary of Administration authority for "leasing for space rules and regulations", which is authority to carry out Code Sections 5A-3-38 to 5A-3-41. Clearly these latter Code Sections deal with the authority to lease, to delegate such authority, the form and length of leases, and so forth and in no way pertain to any authority as exercised in this Emergency Rule.

We request this action because there is no emergency as defined in West Virginia Code 29A-3-15(g) in that this rule is not necessary for the "immediate" preservation of the public peace, health, safety, or welfare.

We request this action because this Emergency Rule was not promulgated in compliance with Code Section 29A-3-15(e) in that this rule is intended to avoid and evade West Virginia Code provisions for the institution and approval of proposed rules. The Smoking Policy of the Division of Personnel, effective December 1, 1990, was in clear violation of a number of West Virginia statutes including State Administrative Policies, Chapter 29A. This Emergency Rule of the Department of Administration is intended to implement that unlawful policy without due process.

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1991 JAN -4 AM 9:41
OFFICE OF WEST VIRGINIA SECRETARY OF STATE

Michael L. Fletcher
Diane G Davis
Donald [illegible]
[illegible]
M [illegible]
[illegible]
Brenda Parsons
Billy B. Gafford
[illegible]
Robert L. [illegible] Jr.
Henry Mullins
Fred C. Thompson, Jr.
[illegible]
[illegible]
J Bess - Non Cig. Smoker
Monte Dadisman
Eric [illegible]
Wm. K. Williams
Randy [illegible] - Non Smoker
Chris Willits
[illegible]
Howard [illegible] Cunningham
Pamela J. Hicks
Linda Cook
Alan [illegible]

Paige Lacalle
Mac Black
L.L. Stine
Charlotte A. Wolfe
Sharon Snead
Joyce E Martin
Cynthia Randolph
Birdie Stowers
Carol B. Dodd
[illegible] (N.S.)
Bashar N. Khoury
Linda Ferguson
[illegible]
B.J. [illegible]
Pat Settle
David Marlow
Leona F. [illegible]
[illegible]
[illegible]
[illegible]
Robert M. Hubbard
Chuck [illegible]
Oreta M. Spencer
Hansel F. [illegible]
Ruth M. Taylor (Non Smoker)
David J Ellis
Clifford M. Vickers
Stewart [illegible]

Sue Stotts
Loretta [illegible]
Paul [illegible]
Tom Sprinkle
David A. Hippchen (non-smoker)
Gary T. Jarrell (non-smoker)
Gypsy L. Fox (non-smoker)
[illegible] Wilson
Robert Williams (non-smoker who believes smokers have a right to be heard before a final smoking policy is implemented)

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1991 JAN -4 AM 9:41
OFFICE OF WEST VIRGINIA
SECRETARY OF STATE

Thornton Cooper
3015 Ridgeview Drive
South Charleston, WV 25303
744-9616; 340-0385
January 31, 1991

The Honorable Ken Hechler
Secretary of State
State Capitol Building
Charleston, WV 25305

Re: Smoking Restriction Guidelines
for West Virginia State Buildings.
148 CSR 7

Dear Mr. Hechler:

By this letter I am offering comments in support of the emergency rule (and any similar permanent rule) filed by the West Virginia Department of Administration last month and bearing the title "Smoking Restriction Guidelines for West Virginia State Buildings". 148 CSR 7.

As you know, I am an attorney, a public employee, a resident of West Virginia, an individual who often visits the State Capitol Building, a member of the Board of Directors (and currently the Vice President) of the American Lung Association of West Virginia, Inc. (ALAWV), and a vocal supporter of protecting the rights of nonsmokers. I am also a member of the West Virginia Tobacco Control Coalition.

Chuck Polan, the Secretary of Administration, and his staff should be applauded for promulgating this rule, which benefits thousands of West Virginians.

For centuries tobacco smoke has been considered the possible cause of health problems for smokers and a nuisance to nonsmokers. During the last several years, mounting evidence has demonstrated that the health effects are much worse. Cigarette smoking is the single most preventable cause of death in the United States and causes about 400,000 premature deaths among smokers in this nation each year. According to a newly released study discussed in the journal of the American Heart Association, secondhand cigarette smoke is the third most preventable cause of death in the United States and causes about 53,000 premature deaths among nonsmokers in the United States each year.

I have enclosed medical literature and clippings on these subjects.

Paragraph 8 of the justification for the emergency rule states:

Tobacco smoke is known to cause lung cancer, thus a smokefree environment will reduce the harm to the public.

The foregoing is a gross understatement. In addition to causing lung cancer, tobacco smoke causes other cancers, emphysema, heart disease, and other diseases, collectively killing about 400,000 smokers and an estimated 53,000 nonsmokers in the United States each year. These mortality figures, do not, of course include the discomfort, misery, lung impairment, other disease, and added expense that cigarette smoke causes smokers and nonsmokers exposed to secondhand smoke.

Tobacco smoke, including secondhand smoke, includes carbon monoxide, radioactive polonium, nicotine, cyanide, and about 4,000 other components. It is indeed unfortunate that in 1991 there are still smokers who, in spite of mountains of medical evidence, think they should have a "right" to smoke in enclosed public areas used by nonsmokers.

I would like to address some issues raised by the rule:

A. IS THERE AN EMERGENCY?

State agencies routinely file "emergency" rules even when the rules are only obliquely related to situations constituting a peril to health, safety, and/or welfare.

However, this rule has a much more demonstrable and calculable relationship to health, safety, and welfare than do most "emergency" rules. According to figures from the 1990 Census, about 0.72% of Americans live in West Virginia. West Virginians die at a higher rate from smoking-related illnesses than do Americans as a whole. But even if the incidence of smoking-related death in West Virginia were identical to the national incidence of such death, 0.72% of 400,000 would translate to about 2,880 premature smoking-caused deaths among smokers in West Virginia annually; 0.72% of 53,000 would translate to about 382 premature deaths annually (more than one per day) among nonsmokers in West Virginia caused by exposure to secondhand smoke.

It is certainly arguable, therefore, that a continuing health emergency exists with respect to exposure of West Virginians to tobacco smoke. This emergency rule has already advanced the interests of health in West Virginia (and may have already saved one or more lives). The rule has certainly improved the air quality in the corridors of the State Capitol Building.

Accordingly, the emergency rule addresses a valid emergency and should be upheld in that context.

B. DOES THE WEST VIRGINIA DEPARTMENT OF ADMINISTRATION HAVE THE AUTHORITY TO ISSUE RULES RELATING TO CONDUCT IN STATE BUILDINGS AND STATE VEHICLES?

By its own terms, the rule is limited in scope to "buildings, offices or other space, motor vehicles and aircraft owned or leased by the State and under the control of the Department of Administration." Moreover, the rule "does not apply to the offices and areas of the West Virginia Supreme Court of Appeals, the Legislature or constitutional officers." The beneficiaries of the rule are members of the public and state employees who transact business or receive service in the buildings, offices, aircraft, and vehicles alluded to earlier.

Under §5A-1-2 of the West Virginia Code, "all records, responsibilities, obligations, assets and property, of whatever kind and character," were transferred from the Division of Finance and Administration to the Department of Administration. Under §5A-1-3, the Secretary of Administration has control and supervision over that Department and is responsible for the work of each of its employees.

Under §5A-3-1, the Legislature created the Purchasing Division of the Department of Administration. The provisions of Article 3 of Chapter 5A "shall apply to all of the spending units of state government, except as otherwise provided" by that article or by other law. §5A-3-1. The Director of the Purchasing Division is appointed by the Secretary of Administration. §5A-1-2.

Under §5A-3-38, "no department, agency or institution of state government shall lease, or offer to lease, as lessee, any grounds, buildings, office or other space except in accordance with this article"...(except the Division of Highways).

Under §5A-3-39, the Secretary of Administration is "authorized to lease, in the name of the state, any grounds, buildings, office or other space required by any department, agency or institution of state government"...

Under §5A-3-40, the Secretary of Administration "shall have sole authority to select and to acquire by contract or lease, in the name of the state, all grounds, buildings, office space or other space, the rental of which is necessarily required by any spending unit"... Moreover, the Secretary is empowered by this section to prevent spending units from making permanent changes in buildings unless he or she determines that a particular change "is necessary for the proper, efficient and economically sound operation of the spending unit."

Under §5A-3-41, the Secretary of Administration is empowered to sign leases "and other instruments for grounds, buildings, office or other space".

It is clear, then, that the West Virginia Legislature empowered the Secretary of Administration to exercise sunstantial powers with respect to buildings and offices.

Furthermore, §5A-3-42 states that the Secretary of Administration "shall have the power to promulgate such rules and regulations as he may deem necessary to carry out the provisions of sections thirty-eight, thirty-nine, forty and forty-one of this article."

Moreover, §5A-3-48 states that the Secretary of Administration "shall promulgate rules and regulations relating to the ownership, purchase, use, maintenance, and repair of all motor vehicles and aircraft owned by the state of West Virginia and in the possession of any department, institution, or agency thereof"...(except for the Division of Highways and the Department of Public Safety).

In §5A-4-1, the Legislature created the General Services Division of the Department of Administration "for the purpose of having the care, custody and control of the capitol buildings." The Secretary of Administration appoints the Director of the GSD. §5A-1-2. Under §5A-4-2, the Director of the GSD is charged with "the full responsiblity for the care, control and custody of the capitol buildings..." (emphasis added)

From the above detailed discussion of the powers of the Secretary of Administration, I submit that his or her control over certain state buildings, offices, vehicles, and aircraft is sufficient and that his or her rulemaking powers are sufficient to sustain the Secretary's authority to promulgate the rule in question.

C. I THERE ANY MERIT IN THE PETITION FILED ON JANUARY 4, 1991, IN OPPOSITION TO THE RULE?

Earlier this month, on January 4, 1991, a typed petition dated January 2, 1991, and bearing the signatures of several dozen employees of the Public Service Commission of West Virginia, was filed with your office in opposition to the rule in question. (I also work for that state agency.)

The main thrust of that petition is that the powers of the Secretary of Administration do not extend to the PSC building, which is located in Charleston at 201 Brooks Street. Rather than elaborating on where the Department of Administration's authority ends and where the Chairman of the PSC's powers begin, I would point out that the argument of the petitioners in academic for at least four (4) reasons:

(1) By its own terms, the rule in question only extends to those "buildings, offices or other space, motor vehicles and aircraft owned or leased by the State and under the control of the Department of Administration." (emphasis added) Hence the rule, by its own terms, is self-limiting. The rule does not claim to extend to the PSC building.

(2) The restrictions on smoking set forth in the rule in question are very similar to a codification of the case law with respect to grievances filed by nonsmoking state employees pursuant to Article 6A of Chapter 29 of the West Virginia Code. That article relates to the Education and State Employees Grievance Board. Grievances relate, among other things to claims..."alleging... any action, policy or practice constituting a substantial detriment to or interference with effective job performance or the health and safety of the employees." §29-6A-2(i). Hence the rejection of the rule would not nullify the limitations on smoking established pursuant to such case law. See, for example, Harman v. West Virginia Department of Human Services, Docket # DHS-88-003, West Virginia Education and State Employees Grievance Board.

(3) The restrictions on smoking set forth in the rule in question are very similar to a personnel policy approved by the West Virginia Personnel Board pursuant to its authority and announced by the Director of Personnel, effective December 1, 1990. The authority of the Board and that Director are set forth in Article 6 of Chapter 29 of the West Virginia Code. The individuals who signed that petition are clearly subject to that policy, a copy of which is attached hereto. Hence the rejection of the Secretary of Administration's rule would not result in the reinstatement of smoking in the PSC building.

(4) Several weeks ago, PSC Chairman Boyce Griffith issued a memorandum stating that the December 1, 1990, policy superseded a less-restrictive smoking policy that he had announced in March 1990. Hence the rejection of the Secretary of Administration's rule would not result in a return to that superseded policy.

CONCLUSION.

For all of the above reasons and that set forth in the attachments and enclosures, I request that your office approve the rule in question.

Sincerely,

Thornton Cooper

...ion, but dismay to displaced work-
...ers.

Company chairman Emmett Boyle operates the plant with supervisors and a steadily rising pool of replacements, who now number 725. Company officials first called the replacements temporary but later, after declaring a negotiating impasse, changed their status to permanent.

More than 1,700 union workers have picketed at Ravenswood since company officials ordered them off the job late on Oct. 31. Union leaders call the labor dispute a lockout, but company officials, having later invited workers

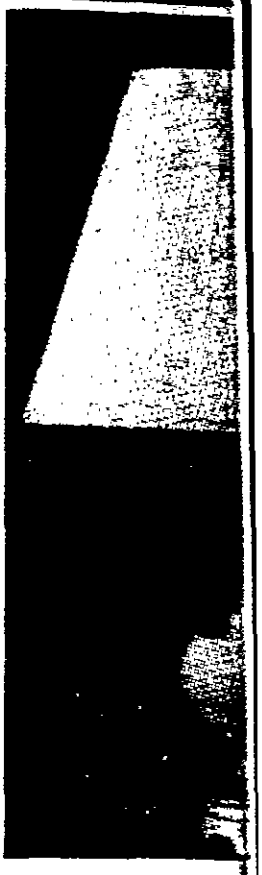
Company and union leaders agree that who fills the jobs depends on the legitimacy of the impasse.

Company officials declared the impasse 20 days into the labor dispute, having made no changes in their Oct. 31 offer.

Some labor experts say a company cannot unilaterally declare an impasse while the other side still submits new and substantially different offers.

Union leaders have contested the impasse to the National Labor Relations Board, which will decide whether workers get their jobs back and receive back pay.

...ny chairm...
it's not an ...
of them all...
Company ...
meet with ...
Wednesday ...
previous sess...



GAZette 1/10/91 p 2B

Passive smoke major killer, study finds

DALLAS (AP) — Passive cigarette smoke kills 53,000 non-smoking Americans each year, making it the third-leading preventable cause of death, the American Heart Association reported Wednesday.

Researchers at the University of California-San Francisco established a link between passive smoke and the development of heart disease, said an article in today's editions of Circulation, a journal of the Dallas-based heart association.

"Passive smoking is a much bigger problem than anyone thought," said Dr. Stanton Glantz, the article's author and an associate staff member of the Cardiovascular Research Institute at UCSF.

Gaston Caperton
Governor

Michael T. Smith
Director

STATE OF WEST VIRGINIA
DEPARTMENT OF ADMINISTRATION
DIVISION OF PERSONNEL

M E M O R A N D U M

TO: All Appointing Authorities

FROM: Michael T. Smith, Director, Division of Personnel

DATE: November 2, 1990

RE: Smoking Policy

On October 18, 1990, the State Personnel Board approved the attached smoking policy. This policy goes into effect on December 1, 1990 and contains responsibilities for all appointing authorities.

After you review the policy, you may call the Employee Relations section of the Division of Personnel at 348-3350. They will be glad to assist you with its implementation.

MTS:MDI:mdi

Attachment

POLICY DOP-P1 SMOKING RESTRICTIONS IN THE WORKPLACE

I. PURPOSE

A. The purpose of this policy is to establish procedures to ensure the right to a healthful, smoke-free environment for each State employee and the public as they transact business with or receive service from the State. Recent studies on the effects of passive smoke inhalation by non-smokers conclude that exposure to secondhand smoke can be harmful to one's health. The working environment should present no unnecessary risk of physical harm or discomfort from environmental tobacco smoke. Furthermore, residents of State facilities, applicants, clients, and visitors should not be exposed to cigarette or any other environmental tobacco smoke. We therefore find it necessary to implement a policy relating to smoking restrictions in all workplaces operated by the State.

II. DEFINITIONS

A. Appointing Authority: An agency head or his/her designee (such as agency supervisors, section or unit heads, or other individuals designated by the agency head).

B. Cigarette: Any lighted tobacco product.

C. ETS: Environmental tobacco smoke; secondhand or sidestream smoke.

D. Proper Ventilation: Smoke exhausted to the outside. The system used to expel the smoke shall not diminish the working conditions of the employees' environment; for example, the method may not affect the building's heating and cooling system.

E. Workplace/Worksite: Any office, facility, building, etc., operated by the State, including State-owned/leased vehicles.

III. POLICY

A. It will be the responsibility of the appointing authority to ensure that all workplaces maintain a healthful, smoke-free environment and to make both employees and the public aware of their responsibility to comply with the smoking restrictions.

1. Appointing authorities have the right and duty to establish a smoke-free environment in State workplaces.

2. Appointing authorities may make reasonable accommodations for smokers, wherever possible and whenever practical. For example:

a. Appointing authorities may establish smoking areas at worksites, as long as the areas are properly ventilated and/or employees and the public have a smoke-free environment with no material effects from secondhand or sidestream smoke.

b. Appointing authorities must prohibit smoking in worksites for employees and the public if accommodations cannot be made without exposing individuals to the effects of secondhand or sidestream smoke.

c. Appointing authorities are not required to make special accommodations for individual smoking areas, but may do so as referenced in this section.

d. In the application of this policy, anytime there is a conflict between the rights of smokers and non-smokers, the rights of non-smokers shall prevail.

B. Public waiting rooms and receiving areas shall be smoke-free, and smoking restrictions shall be actively enforced by the individuals responsible for those areas.

1. The appointing authority shall post signs (worded as specifically as possible) designating smoking and non-smoking areas, if such areas exist.

2. Receptacles should be placed outside all buildings to encourage persons to extinguish smoking products before entering, and an overview of the agency's smoking restriction policy should be posted in all waiting rooms and reception areas (example attached).

3. The agency shall incur all reasonable costs of the materials and their installation.

C. Smoking restrictions shall be enforced at all conferences, meetings, and training sessions conducted by the State and shall be consistent with all other provisions of this policy.

1. All non-State entities using public facilities must conform to the policy.

2. No employees shall be required to subject themselves to the exposure of ETS in conferences or other gatherings that are conducted by organizations outside of State government.

a. Employees may ask the person in charge of such meetings to require a smoke-free environment.

b. If the person in charge fails to enforce smoking restrictions, the employees may return to their regular workplaces.

D. Appointing authorities are encouraged to provide support and assistance to employees in the implementation and enforcement of this policy.

1. Appointing authorities are encouraged to provide and/or refer employees to smoking cessation programs. Attendance at smoking cessation programs conducted and/or sponsored by the State during employees' normal working hours shall be considered an appropriate use of work time.

2. Prohibiting smoking on the employer's premises and selling cigarettes appears to be in conflict, therefore, appointing authorities may want to consider the removal of cigarette vending machines or prohibiting the sale of cigarettes on the premises.

3. Appointing authorities may request assistance from the Division of Personnel and/or the Division of Health when instituting smoking restrictions to ensure that workers' concerns are taken into consideration.

4. Employees who desire to smoke may do so during their scheduled or any other authorized break period(s) provided they use a designated smoking area.

E. All related policies shall be enforced by the appointing authorities.

1. This policy does not supersede any local ordinances or State statutes that are more restrictive and applicable to your workplace, nor does it permit employers to discriminate against smokers who apply for positions.

2. While employers do have the right to make rules for their own premises, to prohibit lawful behavior and the use of lawful tobacco products outside the site of the workplace may be a violation of an individual's right to privacy.

F. State facilities such as hospitals, mental hospitals, and/or prisons shall comply with the aforementioned policy to the maximum extent possible. The only exceptions will be by the express mutual approval of the affected appointing authority and the Director of the Division of Personnel. All exceptions will be made with public health and safety being the prime consideration.

IV. REFERENCES

A. West Virginia Code, Chapter 29, Article 6, Section 7, et. seq.

B. West Virginia Division of Personnel Rules and Regulations, Section 4.04(b).

C. Hartman versus the West Virginia Department of Human Services, Docket #DHS-88-003, West Virginia Education and State Employees Grievance Board.

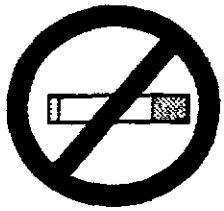
V. EFFECTIVE DATE: December 1, 1990.

Approved and Issued By:

Michael T. Smith

Michael T. Smith, Director of Personnel

Date: October 30, 1990



NO SMOKING POLICY

AS A PROVIDER OF SERVICES TO THE GENERAL PUBLIC, WE CONSIDER IT AN OBLIGATION TO PROVIDE A TOBACCO SMOKE-FREE ENVIRONMENT FOR OUR EMPLOYEES AND FOR THE PUBLIC. WE HAVE PROVIDED DESIGNATED SMOKING AREAS WHICH ARE LISTED BELOW. SMOKING IS PROHIBITED IN *ALL* OTHER AREAS.

THANK YOU
FOR YOUR COOPERATION

THE HEALTH CONSEQUENCES OF INVOLUNTARY SMOKING

a report of the Surgeon General

1986

CHAPTER 1

INTRODUCTION, OVERVIEW, AND SUMMARY AND CONCLUSIONS

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
Rockville, Maryland 20857

Introduction

Development and Organization of the 1986 Report

The 1986 Report was developed by the Office on Smoking and Health of the U.S. Department of Health and Human Services as part of the Department's responsibility, under Public Law 91-222, to report new and current information on smoking and health to the United States Congress.

The scientific content of this Report reflects the contributions of more than 60 scientists representing a variety of disciplines. Individual manuscripts were written by experts known for their understanding of and work in specific content areas. These manuscripts were refined through a series of meetings attended by the authors, Office on Smoking Health staff and consultants, and the Surgeon General.

Upon receipt of the final manuscripts from the authors, the Office and its consultants edited and consolidated the individual manuscripts into appropriate chapters. These draft chapters were subjected to an extensive outside peer review (see Acknowledgments for individuals and their affiliations) whereby each was reviewed by up to seven experts. Their comments were integrated and the entire volume was assembled. This revised edition of the Report was resubjected to review by 17 distinguished scientists outside the Federal Government, both in this country and abroad. Parallel to this review, the entire Report was also submitted to various institutes and agencies within the U.S. Public Health Service for review and comment.

The 1986 Report contains a Foreword by the Assistant Secretary for Health, a Preface by the Surgeon General of the U.S. Public Health Service, and the following chapters:

Chapter 1. Introduction, Overview, and Summary and Conclusions
Chapter 2. Health Effects of Environmental Tobacco Smoke Exposure
Chapter 3. Environmental Tobacco Smoke Chemistry and Exposures of Nonsmokers
Chapter 4. Deposition and Absorption of Tobacco Smoke Constituents
Chapter 5. Toxicity, Acute Irritant Effects, and Carcinogenicity of Environmental Tobacco Smoke
Chapter 6. Policies Restricting Smoking in Public Places and the Workplace

Overview

Inhalation of tobacco smoke during active cigarette smoking remains the largest single preventable cause of death and disability

for the U.S. population. The health consequences of cigarette smoking and of the use of other tobacco products have been extensively documented in the 17 previous Reports in the health consequences of smoking series issued by the U.S. Public Health Service. Cigarette smoking is a major cause of cancer; it is most strongly associated with cancers of the lung and respiratory tract, but also causes cancers at other sites, including the pancreas and urinary bladder. It is the single greatest cause of chronic obstructive lung diseases. It causes cardiovascular diseases, including coronary heart disease, aortic aneurysm, and atherosclerotic peripheral vascular disease. Maternal cigarette smoking endangers fetal and neonatal health; it contributes to perinatal mortality, low birth weight, and complications during pregnancy. More than 300,000 premature deaths occur in the United States each year that are directly attributable to tobacco use, particularly cigarette smoking.

This Report examines in detail the scientific evidence on involuntary smoking as a potential cause of disease in nonsmokers. Nonsmokers' exposure to environmental tobacco smoke is termed involuntary smoking in this Report because the exposure generally occurs as an unavoidable consequence of being in proximity to smokers, particularly in enclosed indoor environments. The term "passive smoking" is also used throughout the scientific literature to describe this exposure.

The magnitude of the disease risks for active smokers secondary to their "high dose" exposure to tobacco smoke suggests that the "lower dose" exposure to tobacco smoke received by involuntary smokers may also have risks. Although the risks of involuntary smoking are smaller than the risks of active smoking, the number of individuals injured by involuntary smoking is large both in absolute terms and in comparison with the number injured by some other agents in the general environment that are regulated to curtail their potential to cause human illness.

This Report reviews the evidence on the characteristics of mainstream tobacco smoke and of environmental tobacco smoke, on the levels of exposure to environmental tobacco smoke that occur, and on the health effects of involuntary exposure to tobacco smoke. The composition of the tobacco smoke inhaled by active smokers and by involuntary smokers is examined for similarities and differences, and the concentrations of tobacco smoke components that can be measured in a variety of settings are explored, as is smoke deposition and absorption in the respiratory tract. The studies that describe the risks of environmental tobacco smoke exposure for humans are carefully reviewed for their findings and their validity. The evidence on the health effects of involuntary smoking is reviewed for biologic

smoking to the lower dose of exposure to tobacco smoke found in nonsmokers. This review leads to three major conclusions:

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.**

The subsequent chapters of this volume describe in detail the evidence that supports these conclusions; the evidence is briefly summarized here.

Environmental Tobacco Smoke Constituents

Important considerations in examining the risks of involuntary smoking are the composition of environmental tobacco smoke (ETS) and its toxicity and carcinogenicity relative to the tobacco smoke inhaled by active smokers. Mainstream cigarette smoke is the smoke drawn through the tobacco into the smoker's mouth. Sidestream smoke is the smoke emitted by the burning tobacco between puffs. Environmental tobacco smoke results from the combination of sidestream smoke and the fraction of exhaled mainstream smoke not retained by the smoker. In contrast with mainstream smoke, ETS is diluted into a larger volume of air, and it ages prior to inhalation.

The comparison of the chemical composition of the smoke inhaled by active smokers with that inhaled by involuntary smokers suggests that the toxic and carcinogenic effects are qualitatively similar, a similarity that is not too surprising because both mainstream smoke and environmental tobacco smoke result from the combustion of tobacco. Individual mainstream smoke constituents, with appropriate testing, have usually been found in sidestream smoke as well. However, differences between sidestream smoke and mainstream smoke have been well documented. The temperature of combustion during sidestream smoke formation is lower than during mainstream smoke formation. As a result, greater amounts of many of the organic constituents of smoke, including some carcinogens, are generated when tobacco burns and forms sidestream smoke than when mainstream smoke is produced. For example, in contrast with mainstream smoke, sidestream smoke contains greater amounts of ammonia, benzene, carbon monoxide, nicotine, and the carcinogens

2-naphthyla ɜ, 4-aminobiphenyl, N-nitrosamine, benz[a]-anthracene, and benzo-pyrene per milligram of tobacco burned. Although only limited bioassay data comparing mainstream smoke and sidestream smoke are available, one study has suggested that sidestream smoke may be more carcinogenic.

Extent of Exposure

Although sidestream smoke and mainstream smoke differ somewhat qualitatively, the differing quantitative doses of smoke components inhaled by the active smoker and by the involuntary smoker are of greater importance in considering the risks of the two exposures. A number of different markers for tobacco smoke exposure and absorption have been identified for both active and involuntary smoking. No single marker quantifies, with precision, the exposure to each of the smoke constituents over the wide range of environmental settings in which involuntary smoking occurs. However, in environments without other significant sources of dust, respirable suspended particulate levels (RSP) can be used as a marker of smoke exposure. Levels of nicotine and its metabolite cotinine in body fluids provide a sensitive and specific indication of recent whole smoke exposure under most conditions.

Widely varying levels of environmental tobacco smoke can be measured in the home and other environments using markers. The time-activity patterns of nonsmokers, which indicate the time spent in environments containing ETS, also vary widely. Thus, the extent of exposure to ETS is probably highly variable among individuals at a given point in time, and little is known about the variation in exposure of the same individual at different points in time.

Lung Cancer

The American Cancer Society estimates that there will be more than 135,000 deaths from lung cancer in the United States in 1986, and 85 percent of these lung cancer deaths are directly attributable to active cigarette smoking. Therefore, even if the number of lung cancer deaths caused by involuntary smoking were much smaller than the number of lung cancer deaths caused by active smoking, the number of lung cancer deaths attributable to involuntary exposure would still represent a problem of sufficient magnitude to warrant substantial public health concern.

Exposure to environmental tobacco smoke has been examined in numerous recent epidemiological studies as a risk factor for lung cancer in nonsmokers. These studies have compared the risks for subjects exposed to ETS at home or at work with the risks for people not reported to be exposed in these environments. Because exposure to ETS is an almost universal experience in the more developed countries, these studies involve comparison of more exposed and less

exposed people, rather than comparison of exposed and unexposed people. Thus, the studies are inherently conservative in assessing the consequences of exposure to ETS. Interpretation of these studies must consider the extent to which populations with different ETS exposures have been identified, the gradient in ETS exposure from the lower exposure to the higher exposure groups, and the magnitude of the increased lung cancer risk that results from the gradient in ETS exposure.

To date, questionnaires have been used to classify ETS exposure. Quantification of exposure by questionnaire, particularly lifetime exposure, is difficult and has not been validated. However, spousal and parental smoking status identify individuals with different levels of exposure to ETS. Therefore, investigation has focused on the children and nonsmoking spouses of smokers, groups for whom greater ETS exposure would be expected and for whom increased nicotine absorption has been documented relative to the children and nonsmoking spouses of nonsmokers.

Of the epidemiologic studies reviewed in this Report that have examined the question of involuntary smoking's association with lung cancer, most (11 of 13) have shown a positive association with exposure, and in 6 the association reached statistical significance. Given the difficulty in identifying groups with differing ETS exposure, the low-dose range of exposure examined, and the small numbers of subjects in some series, it is not surprising that some studies have found no association and that in others the association did not reach a conventional level of statistical significance. The question is not whether cigarette smoke can cause lung cancer; that question has been answered unequivocally by examining the evidence for active smoking. The question is, rather, can tobacco smoke at a lower dose and through a different mode of exposure cause lung cancer in nonsmokers? The answer must be sought in the coherence and trends of the epidemiologic evidence available on this low-dose exposure to a known human carcinogen. In general, those studies with larger population sizes, more carefully validated diagnosis of lung cancer, and more careful assessment of ETS exposure status have shown statistically significant associations. A number of these studies have demonstrated a dose–response relationship between the level of ETS exposure and lung cancer risk. By using data on nicotine absorption by the nonsmoker, the nonsmoker's risk of developing lung cancer observed in human epidemiologic studies can be compared with the level of risk expected from an extrapolation of the dose–response data for the active smoker. This extrapolation yields estimates of an expected lung cancer risk that approximate the observed lung cancer risk in epidemiologic studies of involuntary smoking.

Cigarette smoke is well established as a human carcinogen. The chemical composition of ETS is qualitatively similar to mainstream smoke and sidestream smoke and also acts as a carcinogen in bioassay systems. For many nonsmokers, the quantitative exposure to ETS is large enough to expect an increased risk of lung cancer to occur, and epidemiologic studies have demonstrated an increased lung cancer risk with involuntary smoking. In examining a low-dose exposure to a known carcinogen, it is rare to have such an abundance of evidence on which to make a judgment, and given this abundance of evidence, a clear judgment can now be made: exposure to ETS is a cause of lung cancer.

The data presented in this Report establish that a substantial number of the lung cancer deaths that occur among nonsmokers can be attributed to involuntary smoking. However, better data on the extent and variability of ETS exposure are needed to estimate the number of deaths with confidence.

Respiratory Disease

Acute and chronic respiratory diseases have also been linked to involuntary exposure to tobacco smoke; the evidence is strongest in infants. During the first 2 years of life, infants of parents who smoke are more likely than infants of nonsmoking parents to be hospitalized for bronchitis and pneumonia. Children whose parents smoke also develop respiratory symptoms more frequently, and they show small, but measurable, differences on tests of lung function when compared with children of nonsmoking parents.

Respiratory infections in young children represent a direct health burden for the children and their parents; moreover, these infections, and the reductions in pulmonary function found in the school-age children of smokers, may increase susceptibility to develop lung disease as an adult.

Several studies have reported small decrements in the average level of lung function in nonsmoking adults exposed to ETS. These differences may represent a response of the lung to chronic exposure to the irritants in ETS, but it seems unlikely that ETS exposure, by itself, is responsible for a substantial number of cases of clinically significant chronic obstructive lung disease. The small magnitude of the changes associated with ETS exposure suggests that only individuals with unusual susceptibility would be at risk of developing clinically evident disease from ETS exposure alone. However, ETS exposure may be a factor that contributes to the development of clinical disease in individuals with other causes of lung injury.

Cardiovascular Disease

A few studies have examined the relationship between involun-

the relationship can be made owing to the limited number of deaths in the studies.

Irritation

Perhaps the most common effect of tobacco smoke exposure is tissue irritation. The eyes appear to be especially sensitive to irritation by ETS, but the nose, throat, and airway may also be affected by smoke exposure. Irritation has been demonstrated to occur at levels that are similar to those found in real-life situations. The level of irritation increases with an increasing concentration of smoke and duration of exposure. In addition, participants in surveys report irritation and annoyance due to smoke in the environment under real-life situations.

Determinants of Exposure

Exposure to ETS has been documented to be common in the United States, but additional data on the extent and determinants of exposure are needed to identify individuals within the population who have the highest exposure and are at greatest risk. Studies with biological markers and measurements of ETS components in indoor air confirm that measurable exposure to ETS is widespread. However, within exposed populations, levels of cotinine excretion and presumably ETS exposure vary greatly.

In a room or other indoor area, the size of the space, the number of smokers, the amount of ventilation, and other factors determine the concentration of tobacco smoke in the air. The technology for the cost-effective filtration of tobacco smoke from the air is not currently available, and because of their small size, the smoke particles remain suspended in the air for long periods of time; thus, the only way to remove smoke from indoor air is to increase the exchange of indoor air with clean outdoor air. The number of air changes per hour required to maintain acceptable indoor air quality is much higher when smoking is allowed than when smoking is prohibited.

Environmental tobacco smoke originates at the lighted tip of the cigarette, and exposure to ETS is greatest in close proximity to the smoker. However, the smoke rapidly disseminates throughout any airspace contiguous with the space in which the smoking is taking place. Dissemination of smoke is not uniform, and substantial gradients in ETS levels have been demonstrated in different parts of the same airspace. The time course of tobacco smoke dissemination is rapid enough to ensure the spread of smoke throughout an airspace within an 8-hour workday. In the home, the presence of even one smoker can significantly increase levels of respirable suspended particulates.

These data lead to the conclusion that the simple separ[illegible]
smokers and nonsmokers within the same airspace [illegible]

not elimi[illegible], exposure to ETS, particularly in those settings where exposure is prolonged, such as the working environment.

The exposure of an individual nonsmoker to ETS is also determined by that person's time-activity pattern; that is, the amount of time spent in various locations. For adults, the duration of time spent in smoke-contaminated environments at work or at home is the principal determinant of ETS exposure, along with the levels of smoke in those environments. For infants and very young children, the smoking habit of the primary caretaker, as well as that person's time-activity pattern, is likely to play a major role in determining ETS exposure.

Policies Restricting Smoking

Policies regulating cigarette smoking with the objective of reducing explosion or fire risk, or of safeguarding the quality of manufactured products, have been in force in a number of States since the late 1800s. More recently, and with steadily increasing frequency, policies regulating smoking on the basis of the health risk or the irritation of involuntary smoking have been promulgated.

State and local governments have enacted laws and regulations restricting smoking in public places. These policies have been implemented with few problems and at little cost to the respective governments. The public awareness of these policies that results from the media coverage surrounding their implementation probably facilitates their self-enforcement. Public awareness may best be fostered by encouraging the establishment of these changes at the local level.

Policies limiting smoking in the worksite have also become increasingly widespread and more restrictive. However, changes in worksite policies have evolved largely through voluntary rather than governmental action. In a steadily increasing number of worksites, smoking has been prohibited completely or limited to relatively few areas within the worksite. The creation of a smoke-free workplace has proceeded successfully when the policy has been jointly developed by employees, employee organizations, and management; instituted in phases; and accompanied by support and assistance for the smokers to quit smoking.

This trend to protect nonsmokers from ETS exposure may have an added public health benefit—helping those smokers who are attempting to quit to be more successful and not encouraging smoking by people entering the workforce.

Summary and Conclusions of the 1986 Report

The three major conclusions of this report are the following:

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.**

Individual chapter summaries and conclusions follow.

Health Effects of Environmental Tobacco Smoke Exposure

1. Involuntary smoking can cause lung cancer in nonsmokers.
2. Although a substantial number of the lung cancers that occur in nonsmokers can be attributed to involuntary smoking, more data on the dose and distribution of ETS exposure in the population are needed in order to accurately estimate the magnitude of risk in the U.S. population.
3. 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.
4. 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.
5. Chronic cough and phlegm are more frequent in children whose parents smoke compared with children of nonsmokers. The implications of chronic respiratory symptoms for respiratory health as an adult are unknown and deserve further study.
6. 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., active smoking or occupational exposures, needs investigation.
7. Healthy adults exposed to environmental tobacco smoke may have small changes on pulmonary function testing, but are [illegible]

nary ction as a result of exposure to environmental tobacco smoke alone.

8. 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.
9. Validated questionnaires are needed for the assessment of recent and remote exposure to environmental tobacco smoke in the home, workplace, and other environments.
10. 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.
11. 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.

Environmental Tobacco Smoke Chemistry and Exposures of Nonsmokers

1. Undiluted sidestream smoke is characterized by significantly higher concentrations of many of the toxic and carcinogenic compounds found in mainstream smoke, including ammonia, volatile amines, volatile nitrosamines, certain nicotine decomposition products, and aromatic amines.
2. Environmental tobacco smoke can be a substantial contributor to the level of indoor air pollution concentrations of respirable particles, benzene, acrolein, N-nitrosamine, pyrene, and carbon monoxide. ETS is the only source of nicotine and some N-nitrosamine compounds in the general environment.
3. Measured exposures to respirable suspended particulates are higher for nonsmokers who report exposure to environmental tobacco smoke. Exposures to ETS occur widely in the nonsmoking population.
4. The small particle size of environmental tobacco smoke places it in the diffusion-controlled regime of movement in air for deposition and removal mechanisms. Because these submicron particles will follow air streams, convective currents will dominate and the distribution of ETS will occur rapidly through the volume of a room. As a result, the simple separation of smokers and nonsmokers within the same airspace may reduce, but will not eliminate, exposure to ETS.
5. It has been demonstrated that ETS has resulted in elevated respirable suspended particulate levels in enclosed places.

Deposition and Absorption of Tobacco Smoke Constituents

1. Absorption of tobacco-specific smoke constituents (i.e., nicotine) from environmental tobacco smoke exposures has been documented in a number of samples of the general population of developed countries, suggesting that measurable exposure to environmental tobacco smoke is common.
2. Mean levels of nicotine and cotinine in body fluids increase with self-reported ETS exposure.
3. Because of the stability of cotinine levels measured at different times during exposure and the availability of noninvasive sampling techniques, cotinine appears to be the short-term marker of choice in epidemiological studies.
4. Both mathematical modeling techniques and experimental data suggest that 10 to 20 percent of the particulate fraction of sidestream smoke would be deposited in the airway.
5. The development of specific chemical assays for human exposure to the components of cigarette tar is an important research goal.

Toxicity, Acute Irritant Effects, and Carcinogenicity of Environmental Tobacco Smoke

1. The main effects of the irritants present in ETS occur in the conjunctiva of the eyes and the mucous membranes of the nose, throat, and lower respiratory tract. These irritant effects are a frequent cause of complaints about poor air quality due to environmental tobacco smoke.
2. Active cigarette smoking is associated with prominent changes in the number, type, and function of respiratory epithelial and inflammatory cells; the potential for environmental tobacco smoke exposure to produce similar changes should be investigated.
3. Animal models have demonstrated the carcinogencity of cigarette smoke, and the limited data that exist suggest that more carcinogenic activity per milligram of cigarette smoke concentrate may be contained in sidestream smoke than in mainstream cigarette smoke.

Policies Restricting Smoking in Public Places and the Workplace

1. Beginning in the 1970s, an increasing number of public and private sector institutions have adopted policies to protect individuals from environmental tobacco smoke exposure by restricting the circumstances in which smoking is permitted.
2. Smoking in public places has been regulated primarily by government actions, which have occurred at Federal, State,

and local levels. All but nine States have enacted laws regulating smoking in at least one public place. Since the mid-1970s, there has been an increase in the rate of enactment and in the comprehensiveness of State legislation. Local governments have enacted smoking ordinances at an increasing rate since 1980; more than 80 cities and counties have smoking laws in effect.

3. Smoking at the workplace is regulated by a combination of government action and private initiative. Legislation in 12 States regulates smoking by government employees, and 9 States and more than 70 communities regulate smoking in the private sector workplace. Approximately 35 percent of businesses have adopted smoking policies. The increase in workplace smoking policies has been a trend of the 1980s.
4. Smoking policies may have multiple effects. In addition to reducing environmental tobacco smoke exposure, they may alter smoking behavior and public attitudes about tobacco use. Over time, this may contribute to a reduction in smoking in the United States. To the present, there has been relatively little systematic evaluation of policies restricting smoking in public places or at the workplace.
5. On the basis of case reports and a small number of systematic studies, it appears that workplace smoking policies improve air quality, are met with good compliance, and are well accepted by both smokers and nonsmokers. Policies appear to be followed by a decrease in smokers' cigarette consumption at work and an increase in enrollment in company-sponsored smoking cessation programs.
6. Laws restricting smoking in public places have been implemented with few problems and at little cost to State and local government. Their impact on smoking behavior and attitudes has not yet been evaluated.
7. Public opinion polls document strong and growing support for restricting or banning smoking in a wide range of public places. Changes in attitudes about smoking in public appear to have preceded legislation, but the interrelationship of smoking attitudes, behavior, and legislation are complex.

SMOKERS KILL ABOUT 50,000 OF US EACH YEAR: NEW RISKS DISCLOSED

Involuntary smoking is estimated to kill at least 46,000 adult Americans each year -- approximately the same number killed in all traffic accidents -- according to calculations based upon a number of new medical studies.

The **new medical studies also show that nonsmokers are at risk of many fatal diseases from inhaling other people's tobacco smoke**, not simply lung cancer as previously reported. These diseases include: brain cancer, cancer of the endocrine glands, lymphoma and breast cancer, cerebrovascular disease, diabetes, ulcers, emphysema, and, **most importantly, heart disease.**

Near the end of 1986, the U.S. Public Health Service and the National Academy of Sciences issued two different reports clearly establishing that involuntary inhalation of tobacco smoke causes lung cancer in nonsmokers, and estimating that it caused several thousand lung cancer deaths in nonsmokers each year.

These reports galvanized many federal lawmakers into restricting smoking in federal office buildings, among the armed services, and on most commercial airline flights. The reports also led to more restrictive nonsmokers' rights legislation in many states and cities.

ASH BELIEVES THAT, IF PROPERLY PUBLICIZED, THESE NEW STUDIES COULD PROVIDE THE BASIS FOR EVEN MORE INTENSIVE REGULATION OF THIS DEADLIEST OF ALL FORMS OF AIR POLLUTION.

According to **Wells, A. J.** (1988) An estimate of adult mortality in the United States from passive smoking, *Environment International* Vol. 14, pp. 249-265, approximately 3000 adult Americans die each year of lung cancer caused by inhaling other people's tobacco smoke. However, **almost four times that number** -- 11,000 -- **die each year from OTHER cancers** likewise caused by inhaling other people's tobacco smoke.

Of far greater importance, however, is the new evidence that inhaling other people's tobacco smoke can cause heart disease. According to Wells, **32,000 adult Americans** -- more than ten times the estimates of passive-smoking lung cancer deaths made by the Surgeon General and the National Academy of Sciences -- **die each year of heart attacks caused by breathing other people's tobacco smoke.**

There are now **seven different studies showing the link between exposure to tobacco smoke and heart disease.** They show that **exposure to tobacco smoke can increase the risk of death from heart disease up to 260%**, depending on the circumstances.

The authors of all seven studies conclude that the increased passive smoking risks they observed cannot be ascribed to differences in the major coronary risk factors -- such as obesity -- between passively exposed and nonexposed never smokers.

Even the astounding estimate of 46,000 nonsmoker deaths caused each year by smokers is probably low for several reasons. First, as **Wells** himself notes, his lung cancer estimates are significantly lower than those of other experts such as **Repace** and **Lowrey**. Second, the **figures do not include children,** and therefore omit those who die from sudden infant death syndrome (crib death) and other diseases associated with smoking. Finally, the deaths do not include the many nonsmokers who die each year in fires caused by careless smokers.

ASH URGES ITS READERS TO BRING THIS ARTICLE TO THE ATTENTION OF BOTH STATE AND FEDERAL LEGISLATORS, AND THOSE IN A POSITION TO RESTRICT SMOKING IN PUBLIC PLACES.

ASH'S JOHN BANZHAF INCLUDED IN LIST OF WASHINGTON'S "POWER ELITE"

ASH's Executive Director **John Banzhaf** has been ranked as a member of Washington's "Power Elite," one of the "100 local people who have true clout." The selection was made by *Regardie's*, the Washington metropolitan area's business magazine.

Regardie's described its listing this way: "If the Establishment still exists, this is it." Here is some of what they said about ASH's founder:

"Reformers can be a pain in the neck, but Banzhaf sometimes leaves his adversaries with a severe case of whiplash. Money isn't his motive; he's a professor of law at George Washington University."

"He lives to sue for the sheer glee of sticking it to anyone in his sights, particularly anyone in the tobacco industry. (Banzhaf may be to Camels what Ralph Nader was to Corvairs)."

"POWER PLAYS: Last year was a big one for Banzhaf. . . He was instrumental in getting the nation's airlines to ban smoking on most domestic flights."

YOUR TAX-DEDUCTIBLE CONTRIBUTIONS HELP TO PROTECT YOU AND YOUR LOVED ONES FROM THE DEADLY DANGERS OF OTHER PEOPLE'S TOBACCO SMOKE! PLEASE HELP US TO KEEP FIGHTING FOR YOU!

SMOKING AND HEALTH REVIEW: Action on Smoking and Health, 2013 H St. N.W. Washington DC 20006 Action on Smoking and Health, a national nonprofit tax-exempt organization concerned with the problems of smoking and the rights of nonsmokers is entirely supported by tax-deductible contributions. Regular contributors receive the Smoking and Health Review. Printed portions of the Review may be reprinted with credit to ASH.

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United States
Environmental Protection
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Office of
Air and Radiation
(ANR-445)

June 1989

EPA

Indoor Air Facts No. 5

Environmental Tobacco Smoke

Environmental Tobacco Smoke (ETS) is one of the most widespread and harmful indoor air pollutants. ETS comes from secondhand smoke exhaled by smokers and sidestream smoke emitted from the burning end of cigarettes, cigars, and pipes. ETS is a mixture of irritating gases and carcinogenic tar particles. It is a known cause of lung cancer and respiratory symptoms, and has been linked to heart disease. Breathing in ETS is also known as "involuntary" or "passive" smoking.

What's The Big Deal About A Little Smoke?

In the United States, 50 million smokers annually smoke approximately 600 billion cigarettes, 4 billion cigars, and the equivalent of 11 billion pipesful of tobacco. Since people spend approximately 90 percent of their time indoors, this means that about 467,000 tons of tobacco are burned indoors each year. Over a 16-hour day, the average smoker smokes about two cigarettes per hour, and takes about ten minutes per cigarette. Thus, it takes only a few smokers in a given space to release a more-or-less steady stream of ETS into the indoor air.

In 1985, three major bodies were independently convened to consider the public health implications of passive smoking. Commissioned by the U.S. Public Health Service under the Surgeon General, by the National Research Council (NRC) at the request of EPA, and by the congressionally-mandated Interagency Task Force on Environmental Cancer, Heart, and Lung Disease, the three bodies arrived at a consensus: passive smoking significantly increases the risk of lung cancer in adults. In the words of the Surgeon General, "**a substantial number of the lung cancer deaths that occur among nonsmokers can be attributed to involuntary smoking.**" Moreover, there was agreement that passive smoking substantially increases respiratory illness in children and the NRC recommended eliminating ETS from the environments of small children.

Why ETS Is Harmful

Because the organic material in tobacco doesn't burn completely, cigarette smoke contains more than 4,700 chemical compounds, including: carbon monoxide, nicotine, carcinogenic tars, sulfur dioxide, ammonia, nitrogen oxides, vinyl chloride, hydrogen cyanide, formaldehyde, radionuclides, benzene, and arsenic. These chemicals have been shown in animal studies to be highly toxic. Many are treated as hazardous when emitted into outdoor air by toxic-waste dumps and chemical plants.

There are 43 carcinogenic compounds in tobacco smoke. In addition, some substances are mutagenic, which means they can cause permanent, often harmful, changes in the genetic material of cells. EPA research has shown that ETS is the major source of mutagens indoors when smoking occurs. Higher levels of mutagenic particles are found in homes with ETS than in homes with wood stoves or in outdoor urban environments with numerous diesel trucks and buses.

Many studies have shown that nonsmokers absorb ETS components in their body fluids. The effect of ETS on nonsmokers depends on the duration of exposure. According to the National Research Council, short-term visitors to a smoking area are most likely to be annoyed by the tobacco smoke odors, whereas nonsmoking occupants of the area are more likely to complain about irritating effects to the eyes, nose or throat. Long-term exposure to ETS may lead to more serious health effects.

Impact On Children

Passive smoking induces serious respiratory symptoms in children. Wheezing, coughing and sputum production among children of smoking parents increase by 20 percent to 80 percent depending on the symptom being assessed and the number of smokers in the household. Asthmatic children are particularly at risk.

Children of smokers have significantly higher rates of hospitalization for bronchitis and pneumonia, and a number of studies report that chronic ear infections are more common in young children whose parents smoke. Also lung development is slower in children exposed to ETS. Lung problems caused by ETS exposure in childhood can extend into adult life.

ETS And Cancer

The U.S. Surgeon General and the NRC agree that ETS can cause cancer. The NRC estimates that the risk of lung cancer is roughly 30 percent higher for nonsmoking spouses of smokers than for nonsmoking spouses of nonsmokers. In 1986, an estimated 23,000 U.S. nonsmokers died from lung cancer, and the Surgeon General attributes a substantial number of those deaths to passive smoking.

ETS And Heart Disease

The Interagency Task Force on Environmental Cancer, Heart, and Lung Disease Workshop on ETS concluded that the effects of ETS on the heart may be of even greater concern than its cancer-causing effects on the lungs. ETS aggravates the condition of people with heart disease, and several studies have linked involuntary smoking with heart disease.

ETS's Contribution To Indoor Air Pollution

There are many potential sources of indoor air pollution, including chemicals emanating from building materials, furnishings, and consumer products; gases from combustion appliances like space heaters and furnaces; and biological contaminants from a variety of sources. Because cigarettes, pipes, and cigars produce clouds of tar particles when smoked, ETS is a major contributor of particulate indoor air pollution. ETS also contributes numerous toxic gases to indoor air, including carbon monoxide, formaldehyde and ammonia.

Field studies, controlled experiments, and mathematical models show that, under typical conditions of smoking and ventilation, ETS diffuses rapidly throughout buildings and homes, persists for long periods after smoking ends, and represents one of the strongest sources of indoor-air particulate pollution in buildings where smoking is permitted. Studies of indoor air quality in commercial and public buildings show that particulate levels in areas where smoking is permitted are considerably higher than in nonsmoking areas. Studies using personal air monitors have shown that a single smoker in a home can double the amount of particulate air pollution inhaled by nonsmoking members of the household.

Evidence Of Nonsmoker Exposure

Nicotine, a chemical unique to tobacco, has been found to be a widespread air contaminant in buildings where smoking occurs. Nicotine breaks down into cotinine as it passes through the body. Cotinine can be detected and measured in the saliva, blood, and urine of nonsmokers, indicating they have absorbed tobacco smoke from the air. Concentrations of cotinine have been found in the body fluids of infants of smoking parents, and of adults who were unaware they had been exposed to ETS.

Removal Of ETS From Indoor Air

Environmental tobacco smoke can be totally removed from the indoor air only by removing the source (cigarette smoking). Separating smokers and nonsmokers in the same room may reduce, but will not eliminate, nonsmokers' exposure to tobacco smoke. Placing smokers and non-smokers in separate rooms that are on the same ventilation system also may reduce nonsmokers' exposure to tobacco smoke; this approach, however, will probably not eliminate exposure to tobacco smoke since most pollutants readily disperse through a common air space and since, in public or commercial buildings, most HVAC systems recirculate much of the contaminated indoor air.

In 1981, the American Society of Heating, Refrigerating, and Air-Conditioning Engineers (ASHRAE), in its standard "Ventilation for Acceptable Indoor Air Quality" recommended five cubic feet of outside air per minute per occupant (cfm/occ) in smoke-free office buildings and 20 cfm/occ in buildings where smoking is permitted. These recommendations were not designed to reduce health risks (for example, limiting cancer incidence or eye irritation); rather, the recommendations were intended to control the *odor* from tobacco smoke so that 80 percent of visitors (smokers and nonsmokers combined) to the building find it acceptable. A proposed revision of this standard recommends a minimum of 15 cfm/occ in all buildings.

Research indicates that total removal of tobacco smoke through ventilation is both technically and economically impractical. The effectiveness of air filters for removing ETS particles from the indoor air is generally dependent on the type and efficiency of the air cleaner used; the effectiveness of air cleaners in removing the gaseous components of

tobacco smoke and other air pollutants requires further research.

Since there is no established, health-based threshold for exposure to environmental tobacco smoke and since EPA generally does not recognize a no-effect or safe level for cancer causing agents, the Agency recommends that exposure to environmental tobacco smoke be minimized wherever possible. The most effective way to minimize exposure is to restrict smoking to smoking areas that are separately ventilated and directly exhausted to the outside, or by eliminating smoking in the building entirely.

The Public Reaction To ETS

People are becoming increasingly sensitized to the issue of ETS. Numerous surveys have documented that the majority of both smokers and nonsmokers support restrictions on smoking in public, particularly in the workplace. In a 1987 Gallup National Opinion Survey, 55 percent of all persons interviewed (including smokers and nonsmokers) were in favor of a total ban on all smoking in public places.

As a result, thousands of businesses and hundreds of cities, as well as over 40 states and the District of Columbia restrict smoking in various settings. The number continues to grow rapidly.

Conclusion

EPA shares the recommendations of the 1986 Surgeon General's Report:

- Adults should protect the health of children by not exposing them to environmental tobacco smoke.
- Employers and employees should ensure that the act of smoking does not expose nonsmokers to environmental tobacco smoke by restricting smoking to separately ventilated areas or banning smoking from buildings.
- Smokers should ensure that their behavior does not jeopardize the health of others.
- Nonsmokers should support smokers who are trying to quit.

For More Information

For additional information on environmental tobacco smoke, contact your state or local health departments, nonprofit agencies such as your local Lung Association, Cancer Society or Heart Association, or the following:

Office on Smoking and Health
U.S. Public Health Service
5600 Fishers Lane, Room 1-10
Rockville, MD 20857

Public Relations Office
American Society of Heating
Refrigerating and Air Conditioning
Engineers (ASHRAE)
1791 Tullie Circle, NE.
Atlanta, GA 30329

Office of Cancer Communications
National Cancer Institute
1-800-4-CANCER

Smoking Policy Institute
914 East Jefferson
Suite 219
P.O. Box 20271
Seattle, WA 98102

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

Action on Smoking and Health
2013 H Street, NW.
Washington, DC 20006

Cigarette smoke is only one of many indoor air pollutants that can affect your health and comfort. Other EPA publications concerning the quality of indoor air include:

- *The Inside Story: A Guide to Indoor Air Quality*
- *Directory of State Indoor Air Contacts*
- *Indoor Air Facts #1: EPA and Indoor Air Quality*
- *Indoor Air Facts #2: EPA Indoor Air Quality Implementation Plan*
- *Indoor Air Facts #3: Ventilation and Air Quality in Offices*
- *Indoor Air Facts #4: Sick Buildings*

These publications, as well as additional copies of this fact sheet, are available from:

Public Information Center
U.S. Environmental Protection Agency
Mail Code PM-211B
401 M Street, SW.
Washington, DC 20460

American Lung Association of West Virginia
Controlling Smoking In The Workplace

Financial Issues

September 18, 1990

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Controlling Smoking In The Workplace

Financial Issues

I. Introduction

Many business owners may be more concerned with financial issues of smoking cessation policies than medical or legal issues. This session will demonstrate that there are clear financial benefits to a smoke-free workplace.

II. How Are Financial Benefits Measured?

A. Literally hundreds of studies have been performed

B. Types of studies

1. Measure employee productivity before and after smoking cessation programs.

2. Calculate sick costs and health insurance costs before and after smoking cessation programs, or between smoking workplaces and comparable nonsmoking workplaces.

3. Calculate cleaning and maintenance costs in a smoking environment vs. a nonsmoking environment.

III. The Financial Impacts of Smoking

A. Absenteeism

1. Smoker absenteeism

a. Male smokers are absent an average of 8.5 days per year, those who never smoked are absent an average of 4.9 days per year. (Footnote 1)

b. Example - Dow Chemical

Smokers were absent 5.5 more days per year than nonsmokers. (Footnote 2)

c. At $130 per day empolyee cost (wages and benefits), this results in $468 extra annual absenteeism costs per smoker.

A. Absenteeism (Continued)

2. Absenteeism caused by passive smoke

a. Estimated to be $44 per nonsmoking employee per year. (Footnote 3)

B. Productivity

1. Smokers' loss of productivity

a. Smokers, on average, waste 30 minutes per day more than nonsmokers. (Footnote 4)

b. This amounts to approximately $1,500 lost time per year per smoker. (Footnote 5)

2. Lost productivity effects of passive smoke.

C. Insurance costs

1. Health insurance

a. Health insurance costs approximately $24 more per month per smoker or per smoking dependent. (Footnote 6)

b. Many companies offer nonsmoker discounts.

2. Life insurance

a. One study showed that mortality rates of employees during a certain three year period was 3.5 times greater for smokers than nonsmokers. (Footnote 7)

b. Disability and mortality among smokers costs an estimated $865 per smoker per year. (Footnote 8)

c. Increased risk of disability and mortality of nonsmokers caused by passive smoke are estimated to be $153 per nonsmoker per year. (Footnote 9)

III. The Financial Impacts of Smoking (Continued)

D. Overhead Costs of Smoking

1. Furniture, equipment and cleaning costs

a. Example – smokers' vs. nonsmokers' rooms in hotels.

b. Example – smokers' vs. nonsmokers' seats on buses and airplanes.

c. Typical business equipment and furniture deterioration.

d. Cleaning and maintenance costs.

2. Ventilation costs

a. Ventialation rates must be increased 7 to 10 times (in smoking areas) above what is needed where there is no smoking, and many ventilation systems are unable to deliver a relatively pure environment (where there is) cigarette smoke at any level...and even if they could, the cost would be astronomical. (Footnote 10)

b. One study estimates that additional ventilation cost per smoker per year is $27.57. (Footnote 11)

3. Other costs

IV. A Sample Calculation

A. Exhibit 1

V. Conclusions

A. It is important to demonstrate the financial advantages of smoking cessation policies to management.

B. Primary financial implications of smoking cessation programs are:

Reduced Absenteeism
Increased Productivity
Decreased Insurance Costs
Decreased Cleaning and Equipment Deterioration
Decreased Ventilation Costs
Decreased Various Other Overhead Costs

FOOTNOTES

1. Statistical Abstract of the United States
1981, p. 123

2. The Smoke-Free Workplace
Weis and Miller, 1985, p. 25

3. "Can You Afford to Hire Smokers?"
Personnel Administrator
May 1981

4. "Wall Street Journal", November 7, 1978

5. The Smoke-Free Workplace
Weis and Miller, 1985, p. 34

6. The Smoke-Free Workplace
Weis and Miller, 1985, p. 38

7. "Dow Chemical Company I.Q. Program"
Dow Medical Department
Michigan Division, 1974

8. "Smoking and Alcohol Abuse: A Comparison of Their Economic Consequences"
Luce, B.R. and Schweitzer, S. O.
New England Journal of Medicine
March 9, 1978, pp. 569 - 570

9. "Can You Afford to Hire Smokers?"
Personnel Administrator
May 1981

10. "Energy Management Reports"
July 1980, p. 8

11. "Achtung! Smoking May Be Hazardous to Your Energy Budget"
Solar Age
June 1982, p. 12

EXHIBIT 1

SAMPLE BUSINESS
ESTIMATE OF FINANCIAL IMPACT OF SMOKING

ASSUMPTIONS

NUMBER OF SMOKERS	36
NUMBER OF NONSMOKERS	84
TOTAL EMPLOYEES	120

	BEST CASE	MEDIUM CASE	WORST CASE
ABSENTEEISM COSTS			
SMOKER ABSENTEEISM			
NUMBER OF SMOKERS	36	36	36
NUMBER OF DAYS ADDITIONAL SICK LEAVE PER SMOKER	2.0	3.6	5.2
EXTRA SMOKERS' SICK DAYS	72	130	187
COST PER EMPLOYEE PER DAY	80	130	180
COST OF SMOKER ABSENTEEISM	5,760	16,848	33,696
NONSMOKER ABSENTEEISM DUE TO EFFECTS OF PASSIVE SMOKE			
NUMBER OF NONSMOKERS	84	84	84
COST PER NONSMOKER PER YEAR OF ABSENTEEISM DUE TO PASSIVE SMOKE	30	44	58
COST OF NONSMOKER ABSENTEEISM	2,520	3,696	4,872
TOTAL ABSENTEEISM COSTS	8,280	20,544	38,568
LOST PRODUCTIVITY COSTS			
NUMBER OF SMOKERS	36	36	36
PRODUCTIVITY LOSS PER SMOKER PER YEAR	750	1,500	2,250
TOTAL LOST PRODUCTIVITY COSTS	27,000	54,000	81,000

SAMPLE BUSINESS
ESTIMATE OF FINANCIAL IMPACT OF SMOKING

INSURANCE COSTS			
HEALTH INSURANCE			
NUMBER OF SMOKERS	36	36	36
EXTRA HEALTH INSURANCE EXPENSE PER SMOKER PER MONTH	18	24	30
TOTAL PER MONTH	648	864	1,080
NUMBER OF MONTHS	12	12	12
EXTRA ANNUAL HEALTH INSURANCE EXPENSE	7,776	10,368	12,960
LIFE/DISABILITY INSURANCE			
NUMBER OF SMOKERS	36	36	36
EXTRA COST TO THE BUSINESS DUE TO INCREASED RISK OF DISABILITY AND MORTALITY	600	865	1,130
EXTRA ANNUAL LIFE/DISAB INS EXPENSE	21,600	31,140	40,680
TOTAL EXTRA INSURANCE COSTS	29,376	41,508	53,640
ANNUAL OVERHEAD COSTS			
FURNITURE/EQUIPMENT DETERIORATION	15,000	25,000	35,000
CLEANING/MAINTENANCE	1,800	3,000	4,200
VENTILATION COSTS	750	1,000	1,250
OTHER	500	750	1,250
TOTAL EXTRA OVERHEAT COSTS	18,050	29,750	41,700
SUMMARY			
ABSENTEEISM COSTS	8,280	20,544	38,568
PRODUCTIVITY COSTS	27,000	54,000	81,000
INSURANCE COSTS	29,376	41,508	53,640
OVERHEAD COSTS	18,050	29,750	41,700
TOTAL COSTS OF SMOKING	82,706	145,802	214,908
TOTAL COST PER SMOKER PER YEAR	2,297	4,050	5,970

Excerpted from The Smoke-Free Workplace,

William L. Weis and Bruce W. Miller (1985)
(see Workplace Bibliography)

3

Smoking and Absenteeism

Despite personnel literature replete with articles on the causes, consequences, and cures of absenteeism, personnel theorists rarely seem to consider that employees who take sick leave might simply be sick. Instead, absenteeism is attributed to reasons ranging from management style to the newest and trendiest "stress" syndromes invented by state-of-the-art psychologists.

Whatever the reasons people stay away from work, one simple fact is clear: Smokers do so substantially more often than nonsmokers. Nonsmokers who have observed their co-workers for many years are not surprised by this fact. But many employers who have not would be startled by the differences in absenteeism rates shown in the tables below. Table 3:1, based on data in the 1981 *Statistical Abstract of the United States*, compares the number of days lost per year by those who have never smoked and smokers with various levels of cigarette consumption. Table 3:2, based on data in *Smoking and Health: A Report of the U.S. Surgeon General's Office* (1979), compares the number of workdays lost by smokers and nonsmokers in various age groups. And Table 3:3 summarizes studies done on three groups of employees.

Note that in the organizational studies, the differences between smokers and nonsmokers are greater than those in Tables 3:1 and 3:2. The data in *Statistical Abstracts* come from the Bureau of the Census, which gets its information from the National Health Interview Survey (U.S. National Center for Health Statistics), which relies on self-reporting. The data for 1979, reported in the *1981 Statistical Abstract*, were based on interviews with 157,461 persons. Persons may underreport their own

Table 3:1. Workdays Lost Per Year Related to Number of Cigarettes Smoked (Based on data in *Statistical Abstract of the United States*, 1981, p. 123)

Extent of Daily Cigarette Use	Men		Women	
	Days Absent	Increase over Nonsmokers	Days Absent	Increase over Nonsmokers
Never smoked	4.9	-	6.1	-
Under 15	8.5	+73.5%	8.2	+34.4%
15 to 24	9.6	+95.9%	7.7	+26.2%
25 to 34	6.8	+38.8%	9.3	+52.5%
35 or more	7.0	+42.9%	12.3	+101.6%
All smokers*	8.5	+73.5%	8.2	+34.4%

*Includes those for whom number of cigarettes smoked is unknown.

Table 3:2. Workdays Lost Per Year by Smokers and Nonsmokers in Various Age Groups (Based on 1974 data tabulated in the 1979 Surgeon General's Report)

Age	Never Smoked	Now Smoke	Smokers' Increase	
Men 17+	3.4	5.1	1.7	+50.0%
17-44	3.0	5.5	2.5	+83.3%
45-64	4.4	4.5	0.1	+ 2.3%
Women 17+	4.5	5.6	1.1	+24.4%
17-44	4.3	5.3	1.0	+23.3%
45-64	5.4	6.5	1.1	+20.4%

Table 3:3. Studies by Three Organizations

Employer	Results
Dow Chemical Company[a]	Cigarette smokers were absent 5.5 more days per year than nonsmokers
Calif. Dept. of Water Resources[b]	Smokers took 50% more sick leave than nonsmokers
Major U.S. airline[c]	Smokers took 64% more sick leave than nonsmokers

a. Three-year study of 1,352 employees at Dow's Midland Division.
b. Reported in *DWR News*, Sacramento, Calif., Feb. 1977.
c. Data from 6-month study in the airline's regional administrative offices sent anonymously to Dr. Weis. The average number of sick leave hours was 37.4 hours for nonsmokers and 61.2 for smokers. The study's supervisor confirmed the figures when telephoned, but said that the sensitivity of the issue prevented him from public discussion of the subject. The study had been undertaken in an attempt to prove that absenteeism rates for smokers were *not* higher than those for nonsmokers!

absenteeism rates, especially if they are sensitive to an implied causal relationship with a habit they have been unable or unwilling to break. The absenteeism rates for the airline and Dow Chemical studies came directly from personnel records, which are more reliable.

At Boyd Coffee, in Portland, Oregon, where smoking is banned everywhere except in the parking lot during regular work breaks, the company's 110 employees were absent a total of 175 days in 1980—an average of 1.6 days per employee. At the Austad Company in Sioux Falls, South Dakota, where smoking has always been prohibited, the company's 151 employees missed a total of 260 days during 1982—an average of 1.7 days per employee. These figures are strikingly lower than those in the Na-

tional Health Interview Survey, which found that the average smoker missed 8.35 days in 1979. This rate was 5.3 times the rate for Boyd Coffee employees and 4.9 times that for Austad employees.

These figures even suggest that "passive smoking" (discussed in Chapter 7) increases absenteeism among nonsmoking employees—by impairing their health, their morale (by requiring them to work around smokers), or both.

Cost of Sick Leave

What do these absentee rates mean in dollars and cents? In 1980, Dow Chemical calculated that excess wages were costing $657,000 per year for 2,804 smoking employees at an hourly wage rate of $5.23 per hour. Assuming there are 230 8-hour workdays per year, the excess wage cost per smoker would be $234 per year, excluding benefits and payroll taxes.

If a company's average payroll cost per employee is $30,000 (including benefits and taxes) for an average work year of 230 days (assuming 8 holidays, 3 weeks of vacation, and 7 days of sick leave, the average for smokers and nonsmokers combined), the average daily cost per employee, smoker or nonsmoker, is $130. Using this figure, smokers would cost their company the extra amounts shown in Table 3:4.

The Real Costs Are Even Higher!

Absenteeism costs associated with smoking can be substantially greater when overtime is involved. In the steel industry, for example, the average daily cost per male steelworker is $200 at straight time. Absenteeism changes the estimated costs per year

Table 3:4. Additional Annual Payroll Costs of Smokers (Based on Data from 1981 *Statistical Abstracts of the United States*)

Cigarettes Used Daily	Days Absent Attributable to Smoking	Extra Annual Cost Attributable to Smoking @ $130/day	@ $200/day
Males			
Under 15	3.6	$468	720
15 to 24	4.7	611	940
25 to 34	1.9	247	380
35 or more	2.1	273	420
All males*	3.6	468	720
Females			
Under 15	1.5	195	300
15 to 24	1.6	208	320
25 to 35	3.2	416	640
35 or more	6.2	806	1,240
All females*	2.1	273	420

*Includes those for whom number of cigarettes smoked is unknown.

by the amounts listed in the $200/day column in Table 3:4. But if the absentee's replacement is paid time and a half, the expense would be even greater.

Those assumptions are actually too conservative because they don't consider that employees usually make money for their companies. With professional services, for example, the billing rate can be several times the direct cost of the employee's services. A salaried CPA who is paid $20 per hour may have a client billing rate of $70 per hour—hence loss of that person's services during a peak work season could reduce the firm's profits by an additional $400 per 8-hour day.

The tobacco industry has argued (through a paid consultant) that sick-leave policies are designed so that absences do not

represent an incremental cost to the company. (An example of this argument appears in "The Other Side of the Smoking Controversy," by L. Solomon, in *Personnel Administrator*, March 1983.) This viewpoint is nonsense. Greater rates of absenteeism *always* cost more than lower rates, even if a policy allows unlimited accumulation of leave, or at the extreme, compensates employees for not taking sick leave. The numbers above represent the cost of having more personnel than is necessary—the cost of being overstaffed to make up for excess work-loss days taken by smokers on the payroll.

Employee morale should also be considered when evaluating absenteeism that favors a minority at the expense of their coworkers. Most nonsmokers know that their smoking colleagues take sick leave more often and that the workload increases among the nonsmokers when the smokers are gone. Revulsion to this obviously unfair system led Warren McPherson at Radar Electric to replace his standard sick-leave policy with an extended vacation plan in which each employee is given so many days of paid time-off, regardless of the reason, whenever the employee chooses. His rationale:

> That way all of my employees could enjoy the additional time off from work each year. The smokers could spend the time in bed; the nonsmokers on the ski slopes. And now no one ever has to feign illness just because, for whatever reason, he wants or needs to take a day away from work.

Presumably the ski industry has benefited along with the employees, because Radar Electric hired its last smoker in 1977, and its workforce of 100 had only three smokers at the end of 1983.

Smoking's toll on health is enormous. But despite this well-documented fact and the logical connection between impaired health and absenteeism, many employers seem surprised when

introduced to the absenteeism differentials between smokers and nonsmokers cited in this chapter. We therefore encourage employers to look at their own data. Those who compare a random selection of 100 employees who smoke and 100 who don't will find a difference in sick leave usage that may well convince them to implement a strict clean-indoor-air policy.

4

Smoking and Productivity

"Not only did her smoking ritual shut down her own work—it shut down half of the office," complained Dale Stephens, vice president for data processing with a major West Coast bank. "Every time she struck a match, it was a signal that the time had arrived for another informal—and unauthorized—work break. Four or five of my staff members would move, in unconscious reflex, toward her desk to begin another 10-minutes of chitchat. Every single cigarette she lit was costing me an hour of lost productivity."

Not any more. Corporate headquarters told Stephens to establish whatever smoking policy he deemed appropriate for his department. So he announced a clear policy that smoking would no longer be tolerated during working hours.

Seattle restaurateur Robin Woodward discovered that the drywall workman she hired was spending 30 minutes of each billing hour on his smoking habit. "The painters weren't much better," she said. "They managed to stay on the ladders only 15 minutes at most between smoking breaks. Now my rule for subcontractors is firm: absolutely, positively no smokers."

Lyndon Sanders, owner of the Nonsmokers' Inn in Dallas and the Dollar Inn in Albuquerque, now hires only nonsmokers. His statistics show that they clean rooms 25 percent faster than smokers do.

How Smokers Waste Time

Smoking rituals are often so masterfully executed that most people accept them as a part of the smoker's job description. And

let's not forget the time lost looking for a cigarette, which can even take the smoker out of the workplace to buy another pack. Cleaning and fiddling with a pipe is also good for a major break at least twice during the day.

The tobacco industry argues that all workers waste time whether they smoke or not. Even if this is true, it wouldn't justify time lost due to smoking. The following story—told by a Seattle bank manager who wishes to remain anonymous—illustrates how smoking's role in wasting time is often overlooked at the worksite:

> For years I watched my smoking employees ceremoniously rise from their desks, light up, and gaze contemplatively out the window at Elliott Bay, or engage co-workers in diversionary gab, or just wander aimlessly among the desks as if preoccupied by some complex problem that demanded concentration impossible to achieve while sitting at a desk without a cigarette from which to draw strength and inspiration.
>
> And this all looked perfectly normal to me. Then one day my secretary inquired . . . whether I would fire nonsmokers if they also "made the rounds" and "kept watch for enemy ships on Elliott Bay."
>
> Five minutes later, I watched a programmer as he made the rounds, and I tried to imagine him without his cigarette. I could barely control myself. Such dereliction may go unnoticed in smokers, but not in nonsmokers.
>
> I gave my secretary an immediate raise, announced that smoking during working hours would be banned as of the first of the following month, and—this is why I don't want you to use my name—decided there and then never to hire another smoker.

A smoking ban is also an effective way to keep break times equal among smokers and nonsmokers—especially when worker morale and productivity are important. Mark Miller is a maintenance man for Lincoln General Hospital in Lincoln, Nebraska.

He has reported that his boss criticized him severely for taking a few extra minutes for his break. "The boss said more or less that he wanted me to hurry up and get something done. It's all right for smokers to sit down or stop what they are doing and go have a smoke. Just because I don't smoke I'm getting penalized for taking a little longer on break." Miller says his morale went downhill and that his response is to "do what I have to do and that's it. I don't go out of my way to do anything extra."

David Hesketh, manager of Yonny Yonson's, a sandwich and frozen yogurt shop in Seattle, Washington, agrees that smokers take not only extra time but also extra breaks. When he was a cook at a Denny's restaurant, Hesketh says, "other cooks who were smokers were taking up to two smoking breaks an hour—which meant at least ten minutes of lost time that I somehow had to compensate for with faster work." Adding smoking waiters and waitresses to the picture, he concludes:

> The nonsmokers were substantially subsidizing their smoking colleague's down-time with virtually no work breaks and speed-ups . . . The inherent injustice in that environment was a continuous source of morale problems for those employees who were contributing the most to the restaurant.

At Yonny Yonson's, Hesketh hires "only heads-up people . . . bright and quick to serve . . . who, by and large, don't smoke," because "employee morale is very high and I intend to keep it that way. One smoker taking unscheduled work breaks—hence putting more pressure on my other employees—could destroy the morale we have worked hard to cultivate."

Statistical Studies

How much time is actually lost to the smoking ritual? Several businesses and consulting firms have measured the amount of

time the average smoker loses to the smoking rituals of lighting, puffing, staring, appearing deep in thought, and enjoying an informal workbreak. The Major Pool Equipment Company in Clifton, New Jersey, found that smokers lost 2 to 10 percent of their efficiency, depending on how frequently they smoked.[1] The average smoker wasted about 30 minutes a day to the smoking ritual—some 6 percent of the work year.

The Robert E. Nolan Company, a consulting firm in Simsbury, Connecticut, watched cigarette smokers waste 30 minutes per day, but found that pipe smokers wasted 55 minutes per day, or 11 percent of the work year.[2]

If we accept the finding that smokers waste 30 minutes a day, workers paid $25,000 per year would waste $1,500 of their employers' money, and 94 nonsmokers could do the same amount of work as 100 smokers. These figures do not include lost productivity of offended nonsmokers or their increased absenteeism (discussed in Chapter 3). Nor do they include billing time lost when astute clients protest.

While the smoking employee is gazing off into space, the client is still being billed at the usual rate. Occasionally a client will have the opportunity to observe this subtle form of theft and balk at payment, as did the production editor of a business journal. She timed how long the paste-up artist in the typesetting shop took to light and smoke cigarette after cigarette. Ten minutes of each hour went up in smoke. When she demanded a 6 percent reduction of the artist's bill, she got it. (She should have asked for 16 percent!)

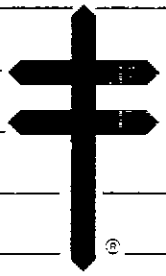
When time lost to smoking is combined with time lost to absenteeism, the average smoker loses 17 days per year—which means that the work done by six smokers could be done by five nonsmokers.

References

1. Carlson, R., *Smoking or Health in New Jersey: A Progress Report on Making Nonsmoking the Norm*, New Jersey State Department of Health, Occupational Health Program, 1981, p. 24.

2. *Wall Street Journal*, November 7, 1978.

health effects of smoking on children



OFFICIAL STATEMENT
AMERICAN THORACIC SOCIETY
Medical Section of
AMERICAN LUNG ASSOCIATION

THE URGENCY OF CREATING SMOKE-FREE FAMILIES

A 1985 Gallup survey, commissioned by the American Lung Association, showed an overwhelming majority of nonsmokers – and a sizable majority of smokers themselves – agreed with this statement: "Smokers should refrain from smoking in the presence of nonsmokers."

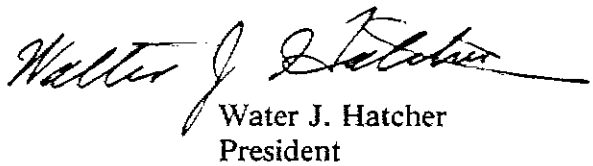
Those who agreed with this statement were asked where they thought it applied. In every public place? At work? In the home?

Although more than three-quarters said it applied in every public place – and nearly half believed smoking should be restrained at the workplace – only a minority felt the statement was relevant to the home.

The finding is a surprising and disconcerting one, since a solid body of research clearly indicates there are especially harmful effects of passive – or involuntary – smoking on children.

This official American Thoracic Society statement outlines the adverse effects of cigarette smoke on the health of children – from conception through adolescence. It provides critical information for parents, teachers, and all health professionals who work with children and their parents.

It is because of these adverse effects that the American Lung Association is launching a nationwide campaign to create "the smoke-free family." This ATS statement documents the research evidence that makes this campaign one of utmost urgency.



Water J. Hatcher
President
American Lung Association
January, 1986

HEALTH EFFECTS OF SMOKING ON CHILDREN

AMERICAN THORACIC SOCIETY, MEDICAL SECTION OF AMERICAN LUNG ASSOCIATION

THIS OFFICIAL STATEMENT OF THE AMERICAN THORACIC SOCIETY WAS ADOPTED BY THE ATS BOARD OF DIRECTORS, NOVEMBER 1984

Introduction

Tobacco smoking is the number 1 avoidable cause of mortality in the United States (1). The possible harmful effects of tobacco smoke on the health of children in this country have become of great concern to health professionals and lay public alike. The Scientific Assembly on Pediatrics of the American Thoracic Society, composed primarily of pediatricians who are specialists in the area of lung disease in childhood, has prepared this statement in order to (*1*) summarize the health effects of cigarette smoke on infants and children, and (*2*) recommend specific actions to minimize or eliminate this unnecessary health hazard.

Scope of the Problem and the Known Health Effects

Currently there are about 53 million active cigarette smokers in the United States, an absolute number that has remained virtually unchanged over the past 20 yr (2). About 30% of all adults smoke; male smokers outnumber females but the difference is progressively diminishing (3). In 1979, it was estimated that the total health costs associated with smoking exceeded $25 billion per year, a figure that may be an underestimate as the health effects of passive smoking are difficult to document (1).

The majority of smokers start smoking in adolescence; the current average age of smoking onset for both sexes is about 16 yr. Teenage smoking has shown a slight decline in recent years, especially in girls (4). Nonetheless, by 17 to 19 yr of age about one fifth of all teenagers smoke regularly (1). The total number of children who are exposed each year to tobacco smoke by placental transfer of byproducts, passive inhalation, or active smoking is difficult to estimate.

Tobacco smoke can harm children via: (*1*) the effects of smoking during pregnancy on fetal and child outcome, (*2*) the effects of passively inhaled smoke on respiratory symptoms and lung function in childhood, and (*3*) the effects of active smoking on the respiratory system. The current state of knowledge concerning each of these three areas is summarized below.

Maternal smoking decreases birth weight and increases perinatal mortality (4–7). The dose-dependent reduction in birth weight averages about 200 grams and has been shown to be independent of possible confounding factors such as socioeconomic status and maternal age. Cessation of smoking early in pregnancy can result in normal birth weight. Mothers who smoke have an increased rate of placenta previa, abruptio placenta, antepartum hemorrhage, and premature delivery. These complications of pregnancy lead to an increased number of stillbirths and neonatal deaths from respiratory distress syndrome, asphyxia, pneumonia, and immaturity. Perinatal mortality among the offspring of heavy smokers is increased by about 35% and is dose dependent (6). It has been estimated that maternal smoking may lead to about 5,000 extra perinatal deaths each year in the United States (8).

These adverse health effects of maternal smoking on fetal well-being probably result from maternal systemic absorption of toxins such as carbon monoxide and nicotine. Carbon monoxide readily crosses the placental barrier, and the resulting tissue hypoxemia may be one of the causes of the observed decrease in birth weight. Nicotine is a potent placental vasoconstrictor; recurrent episodes of placental vasoconstriction may lead to undernourishment of the fetus and a decrease in birth weight (*5*, 7).

Several adverse health effects resulting from passive smoking during childhood have been demonstrated. Children who receive a heavy passive exposure to cigarette smoke have more upper and lower respiratory tract infections than other children (9–11). Passive smoking appears to be a risk factor for recurrent otitis media, recurrent tonsillopharyngitis, and the need for tonsillectomy and adenoidectomy (12). The incidence of severe lower respiratory tract infections is increased in infants who are passive smokers and is to some extent dose related. A significantly increased risk for hospital admission for a lower respiratory tract infection in passive smoking infants under 1 yr of age has been demonstrated (13). Passive smoking has been shown to be one of many risk factors for Sudden Infant Death Syndrome that is independent of other confounding factors (14). The mechanism of this association is not yet known.

Small decreases in pulmonary function have been found in some studies of passive smoking in childhood while others have found no such trend (15–18). A decrease in lung function in passive smokers may be the result of their increased frequency of lower respiratory infections or a direct effect on airway function.

Cigarette smoke may have an adverse effect on the health of children with preexisting lung disease, especially asthma. Tobacco smoke can precipitate bronchospasm as a nonspecific irritant or via an IgE-mediated pathway. Cessation of parental smoking leads to decreased respiratory symptoms in childhood asthmatics (19).

Active smoking in adolescents is not a major cause of respiratory morbidity, but both clinical symptoms and pathologic changes have been demonstrated in teenage smokers. Autopsy studies performed on teenage victims of sudden death have shown that pathologic changes begin within the first few years of active smoking (20). The changes are those of early small airways disease and include inflammatory bronchiolitis, epithelial hyperplasia, loss of bronchial epithelium, and bronchial wall inflammation. Teenage smokers have increases in respiratory symptoms and decreases in lung function when compared to control subjects (21–23).

Probably the most important aspect of smoking in children is that about two thirds of adult smokers begin the habit during adolescence. The majority of smokers have begun by 16 yr of age (1). At present, approximately one fifth of all high school seniors are regular smokers. If cigarette smoking is considered an epidemic, as well it should be because it causes up to 325,000 premature deaths per year, then the answer, as in any epidemic, will be found in prevention, not cure (1).

Many factors are associated with a teenager's decision to start smoking. Among these are family dynamics, socioeconomic status, health habits and knowledge, number of smokers in the household, siblings who smoke, peer pressure, and an adolescent's natural urge to become autonomous and rebel. Behavioral and social scientists have advanced a number of theories to explain the adoption of smoking (1, 2). A common thread to these theories is that as children mature into adults there are many influences on them to begin smoking that may overpower their knowledge of the adverse health effects. Numerous efforts have been made to educate adolescents about the harmful effects of tobacco smoke with the hope that education would lead to avoidance. Virtually all such studies have come to the same conclusion: You can educate teenagers about the health effects of smoking, but that alone will not prevent them from smoking. For education to lead to prevention, efforts will have to be directed towards children of grammar school age or even younger.

Summary and Suggestions for Action

Cigarette smoke has adverse effects on the health of children from conception through adolescence, and most adult smokers start during childhood. For these reasons smoking prevention must become a major focus for all who are interested in child health. As pediatricians and physicians whose expertise is in the area of lung disease in children, the Scientific Assembly on Pediatrics of the American Thoracic Society has drafted the following set of guidelines and recommendations for its membership, the membership of the American Thoracic Society and the American Lung Association, and other health professionals:

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1. Information concerning the adverse health effects of smoking should be incorporated as part of the general health curriculum beginning in the earliest grades of school.

2. The American Lung Association should, in cooperation with other private and federal funding agencies, fund research designed to explore innovative methods of smoking prevention. Such efforts should be long-term and especially directed towards young children.

3. Health professionals should encourage and support regulations banning smoking in public areas, especially those where children are likely to be exposed such as hospitals, public transport, and schools.

4. Questions concerning cigarette smoke exposure should become a routine part of the history of all children. Strong recommendations to parents to stop exposing their children to cigarette smoke should be made with the full realization of and sensitivity to the guilt and anger such a recommendation may provoke.

5. Health professionals should set an example and not smoke, nor allow smoking in their offices.

6. The American Lung Association and other private and federal agencies should start a large, coordinated national campaign directed at young parents to educate them on the effects of passive smoking on the fetus and young child. Such a campaign could include written material, posters, magazine articles, and use of the visual media. The campaign should be practical, hard-hitting, and take into account the age group at which it is targeted.

7. The American Lung Association and other private and federal agencies should continue and expand upon efforts to prevent teenagers from starting to smoke. Such efforts should be blunt and directed at the various determinants of teenage smoking such as peer pressure, the desire for autonomy, and manipulation by tobacco advertisements.

8. More research is needed in the area of passive smoking and its relationship to respiratory infections and lung function in childhood. Such studies should concentrate on the interaction of passive smoking with respiratory tract infections, atopic phenomena, and bronchial reactivity.

This statement was prepared by an Ad Hoc Committee of the Scientific Assembly on Pediatrics. The Committee members were as follows:

MICHAEL WALL, M.D., *Chairman*
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February 4, 1991

NOTICE OF EMERGENCY RULE DECISION BY THE SECRETARY OF STATE

AGENCY: Department of Administration

RULE: New Rule, Series 7; Smoking Restriction Guidelines for West Virginia State Buildings

DATE FILED AS AN EMERGENCY RULE: December 26, 1990

DECISION NO. 12-91

Following review under WV Code §29A-3-15a, it is the decision of the Secretary of State that the above emergency rule be approved. A copy of the complete decision with required findings is available from this office.

Ken Hechler

KEN HECHLER
Secretary of State

FILED
1991 FEB -5 AM 11:30
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DECISION EMERGENCY RULE DECISION (ERD 12-91)

AGENCY: Department of Administration
RULE: New Rule, Series 7, Smoking Restriction Guidelines for West Virginia State Buildings
FILED AS AN EMERGENCY RULE: December 26, 1990

par. 1 The Department of Administration (Department) has filed the above new rule as an emergency.

par. 2 West Virginia Code §29A-3-15a requires the Secretary of State to review all emergency rules filed after March 8, 1986. This review requires the Secretary of State to determine if the agency filing such emergency rule: 1) has complied with the procedures for adopting an emergency rule; 2) exceeded the scope of its statutory authority in promulgating the emergency rule; or 3) can show that an emergency exists justifying the promulgation of an emergency rule.

par. 3 Following review, the Secretary of State shall issue a decision as to whether or not such an emergency rule should be disapproved [29A-3-15a(a)].

par. 4 (A) Procedural Compliance: WV Code 29A-3-15 permits an agency to adopt, amend or repeal, without hearing, any legislative rule by filing such rule, along with a statement of the circumstances constituting the emergency, with the Secretary of State and forthwith with the Legislative Rule-Making Review Committee (LRMRC).

par. 5 If an agency has accomplished the above two required filings with the appropriate supporting documents by the time the emergency rule decision is issued or the expiration of the forty-two day review period, whichever is sooner, the Secretary of State shall rule in favor of procedural compliance.

par. 6 The Department filed this emergency rule with supporting documents with the Secretary of State on December 26, 1990 and with the LRMRC on December 26, 1990.

par. 7 It is the determination of the Secretary of State that the Department has complied with the procedural requirements of WV Code §29A-3-15 for adoption of an emergency rule.

par. 8 (B) Statutory Authority -- WV Code §5A-4-2 reads in part:

5A-4-2. Care, control and custody of capitol buildings and grounds.

The director shall be charged with the full responsibility for the care, control and custody of the capitol buildings.

par. 9 WV Code §5F-2-2(a)(10(11) further states:

(a) Notwithstanding any other provision of this code to the contrary, the secretary of each department shall have plenary power and authority within and for the department to:

(10) Supervise internal management;

(11) Promulgate rules, as defined in §29A-1-2 of this code, to implement and make effective the powers, authority and duties granted and imposed by the provisions of this chapter, such promulgation to be in accordance with the provisions of §29A-1-1 et seq. of this code.

par. 10 It is the determination of the Secretary of State that the Department has not exceeded its statutory authority in promulgating this emergency rule.

par. 11 (C) Emergency: WV Code 29A-3-15(g) defines "emergency" as follows:

(g) For the purposes of this section, an emergency exists when the promulgation of a rule is necessary for the immediate preservation of the public peace, health, safety or welfare or is necessary to comply with a time limitation established by this code or by a federal statute or regulation or to prevent substantial harm to the public interest.

par. 12 There are essentially three classes of emergency broadly presented with the above provision: 1) immediate preservation; 2) time limitation; and 3) substantial harm. An agency need only document to the satisfaction of the Secretary of State that there exists a nexus between the proposal and the circumstances creating at least one of the above three emergency categories.

par. 13 The facts and circumstances as presented by the Department are as follows:

The working environment of State employees should present no unnecessary risk of physical harm or discomfort from environmental tobacco smoke which is known cause of lung cancer.

As an employer with the responsibility to provide a safe and healthful work environment free from recognized and avoidable hazards, it is in the public interest for the Department of Administration, as the custodial agent for State owned, rented, leased facilities, to direct that a smoke free environment be assured not only for each State employee, but for the public as well, as they transact business with or receive services from the State.

par. 14 It is the determination of the Secretary of State that this proposal qualifies under the definition of an emergency as defined in 29A-3-15(g) . . ."immediate preservation of public peace, health, safety or welfare" and "prevent substantial harm to public interest."

par. 15 This decision shall be cited as Emergency Rule Decision 12-91 or ERD 12-91 and may be cited as precedent. This decision is available from the Secretary of State and has been filed with the Department of Administration, the Attorney General and the Legislative Rule Making Review Commission.

Ken Hechler

KEN HECHLER
SECRETARY OF STATE

Entered_____

FILED
1991 FEB -5 AM 11: 30
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