

PUBLIC SMOKING

The tobacco industry acknowledges that there is controversy over many aspects of the general problem of smoking and health. There is disagreement among medical experts as to whether the reported associations between smoking and various diseases are causal or not. Accordingly, there is a continuing need for further research into the causes of such diseases and it remains the policy of the tobacco industry to support such research.

"Public Smoking," to wit, smoking in the presence of another person, has become increasingly the subject of debate with mounting pressure for restriction. This issue has also been variously referred to as "passive smoking" or "involuntary smoking"; however, in this paper these terms are intended to be subsumed under "Public Smoking."

It is self-evident that, since there is disagreement among medical experts as to whether the reported associations between smoking and various diseases are causal or not, there is ^{certainly} no compelling evidence amounting to proof that ~~there is any causal link between~~ "Public Smoking" ^{causes} and ~~various diseases~~ ^{in the nonsmoker.} This paper will, ~~therefore~~ address the ^{of public smoking} issue according to the present state of scientific knowledge* but will make no judgments on the varying views of the experts which are quoted or referred to.

*This paper will be updated periodically. Accordingly, before use it would be well to check to determine that the information to be used is up to date. (with?)

I. Public Smoking as a Public Issue

In the last few years, controversy has arisen about public smoking and health; claims and charges have escalated; campaigns to ban or restrict smoking in public have taken place and continue to increase. Thus, the public smoking issue has become a matter where the tobacco industry's position should be clear.

There are three major points upon which to focus.

First, claims that tobacco smoke in the atmosphere causes disease in nonsmokers are unsubstantiated; nevertheless, a large portion of the population--both smokers and nonsmokers--believe these claims.

Second, leaders of the drive to prohibit smoking in public frequently resort to scare tactics to make nonsmokers believe their health is being harmed by tobacco smoke in the atmosphere.

Third, against this background of misinformation public bodies are making rules about public smoking that intrude into personal liberty.

Although the public smoking issue arose in the 1970's, it stemmed from the smoking and health controversy of the last 25 years. As a supplementary method to dissuade people from smoking, the notion of a crusade to make smoking socially unacceptable was evolved. The mechanism to do this was to paint smoking as a health hazard to the

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nonsmoker.

At the 3rd World Conference on Smoking and Health in New York in 1975, this was considered a viable plan for curtailing smoking. Since then, efforts along these lines have intensified.

The problem that advocates of this tactic faced in 1975, and still face today, is the fact that there is no proof that tobacco smoke in the atmosphere causes disease in the nonsmoker.

✓ The most that can be said about atmospheric tobacco smoke is the possibility that there is a small group of exceedingly sensitive or otherwise ill people who have conditions which may be exacerbated by various environmental influences including ~~environmental~~ tobacco smoke. However, the contribution of tobacco smoke to atmospheric constituents is minimal.

✓ Even so, efforts were undertaken ^{by a small group of anti-smokers} to make non-smokers believe that their health was being adversely affected by atmospheric tobacco smoke. Thus, a small but determined corps of antismokers set out to get smoking banned in the work place, either by court or governmental regulation; to get laws passed regulating smoking in public places; and to get smoking restrictions on public transport. These forces are still at work and today the public smoking issue is receiving widespread attention. In generating this public issue, the corps of antismokers

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uses tactics based on misinformation and emotionalism not justified by facts.

II. Atmospheric Tobacco Smoke and Health

There is no scientific proof that tobacco smoke in the atmosphere causes disease in nonsmokers. Despite the contrary claims of a few, the view that atmospheric tobacco smoke does not present a health hazard to the non-smoker is supported by numerous reports of independent scientists and governmental bodies that have examined this issue. For example, ~~the 1973 report by Fletcher, et al. an expert group appointed by the United Kingdom antismoking organization known as Action on Smoking and Health concluded that there is no "evidence" that smoking is "dangerous to healthy nonsmokers."~~

✓ In 1974, a workshop (organized, among others, by Dr. Rylander of the Universities of Geneva and Gothenburg) was attended by scientists from all over the world to consider the health consequences of atmospheric tobacco smoke. These scientists were unable to conclude that cigarette smoking is a hazard to nonsmokers. Further, ^{workshop summary} ~~these scientists~~ stated that:

"For the majority of the population the average exposure burden due to environmental tobacco smoke is probably much lower than that due to industrial air pollutants and in many cases also environmental air pollution or the lung burden due to dust clouds or other indoor air pollutants."

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In 1971, a joint study by the Federal Aviation Administration, the United States Department of Health, Education and Welfare and the National Institute of Occupational Safety and Health examined the health aspects of smoking on transport aircraft. Its conclusion was as follows:

"... it is concluded that inhalation of the by-products from tobacco smoke generated as a result of passengers smoking aboard commercial aircraft does not represent a significant health hazard to nonsmoking passengers." ³

This conclusion is supported by that of the U. S. Interstate Commerce Commission's study of smoking on buses:

"We agree with the examiner's conclusions that petitioner has failed adequately to demonstrate the deleterious effects of second-hand smoke upon the health of motor bus passengers." ⁴

In 1977, a symposium on the topic of smoking in the work place sponsored by the Bavarian Academy of Industrial and Social Medicine was held in Munich, Germany and attended by eminent German scientists, lawyers, as well as government leaders. The chairman of this symposium, Professor Doctor H. Valentin of the University of Erlangen-Nuremburg stated as follows:

"In conclusion, with regard to medical and legal facts of passive smoking at the work place, the following must be considered. Under our present day work place conditions, no clear and significant untoward health effects from passive smoking have been shown. Therefore, we should, as in other everyday situations, observe the following rules:

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' . . . as much state intervention
as necessary - as much freedom as
possible.' " 5

Quite recently (1978), the German Society of Occupational Medicine--which includes approximately 700 scientists and other persons interested in occupational health--examined the issue of smoking in the work place and found that

"To date, according to our knowledge, scientifically unequivocal and objective proof of damage to health, as a result of passive smoking, has not been established in any population group." 6

Accordingly, the Society concluded that a smoking ban in the work place cannot be justified on a scientific basis.

In view of these conclusions by independent scientists and governmental bodies, it is not surprising that some of the most avowed critics of tobacco have acknowledged that smoking has not been established as a cause of disease in nonsmokers.

✓ For example, Dr. Ernest L. Wynder of the American Health Foundation admitted that he does not believe that "passive smoking really hurts the health of somebody who sits next to you. . ." 7 Dr. Jonathan Rhoades, Chairman of the National Cancer Advisory Board, admitted in commenting upon atmospheric tobacco smoke and health that to his knowledge "it is not, in fact, actually harmful." 8
✓ And on cancer, Dr. E. Cuyler Hammond of the American Cancer Society stated that there "was no shred of evidence"

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that a nonsmoker can get cancer from "second hand" smoke and that there is a lot of evidence that he cannot.

Dr. Hammond added that to suggest passive smoking could cause cancer is dishonest, and that he would be prepared to testify as much in a court.⁹ And even the then Surgeon General of the United States-- Dr. Jesse Steinfeld--admitted after the 1972 Public Health Service Report was issued that he could not "say with certainty that exposure to tobacco smoke can cause serious illness in nonsmokers."¹⁰ As further examples, the footnote lists ~~a dozen~~ others* who are usually critical of smoking and who have voiced the view that atmospheric tobacco smoke has not been established as being harmful to the health of ^{normal} nonsmokers.

These opinions are supported by the findings of Hinds and First of the Harvard School of Public Health. Their study, which was financed by the Massachusetts Lung Association, measured tobacco smoke (by extrapolating from nicotine) in various public places such as restaurants, cocktail lounges, bus and airline terminals and stu-

(not Paul) [Possibly add]:

Poul Astrup, Oscar Auerbach, Jol R. Baker

*Wilbert S. Aronow, Richard Doll, Dean F. Davies, John R. Goldsmith, Gio Gori, Roy Korson, David Owen, Irwin Schmeltz, ~~Dietrich Hoffmann~~, Reuel Stallones, R. D. Stewart, and ~~Luther Terry~~ ^{and}

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dent lounges, and found that the amounts were very small indeed.¹² In editorial comment, appearing in the New England Journal of Medicine which reported this study, Dr. Gary Huber of the Harvard Medical School stated:

"Under the most severe concentrations of exposure in their study, the non-smoker could consume an amount of tobacco so small that the risk of development of any adverse health effect would be non-existent, on the basis of any available data in the literature today."¹³

✓ Scientific facts notwithstanding, claims are sometimes made that ~~smoking~~ *environmental tobacco smoke* causes chronic degenerative diseases in nonsmokers. However, one recent study reviewed the data from a number of other studies, including an American Cancer Society epidemiological study, and found no evidence that nonsmokers constantly exposed to tobacco smoke have an increased risk of lung cancer.¹⁴

✓ It is frequently asserted that atmospheric tobacco smoke causes or contributes to the development of atherosclerosis in nonsmokers, as a result of carbon monoxide. Those that make this assertion point to *the earlier* studies by Astrup, et al., which reported a higher cholesterol content in animals *fed a high cholesterol diet and* chronically exposed to carbon monoxide compared with animals not so exposed.¹⁵ ~~while~~ *these* studies also reported that the exposed animals had arterial changes indistinguishable from early atherosclerosis, ~~they ignored observations in humans (bridge and tunnel workers) indicating that persons chronically exposed to~~

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~~carbon monoxide do not have any increased incidence of atherosclerosis.~~¹⁶

For those who advance the carbon monoxide-atherosclerosis theory, the Astrup work is conclusive; anyone suggesting a contrary view is discounted. Very recently, however, Astrup has admitted that he has been unable to reproduce his previous experiment. ~~He stated~~

(Insert A here)
~~that his~~ "present study suggests that applying the generally accepted criteria for intimal damage no direct toxic effect of CO can be demonstrated."¹⁷ → [Note: see p. 26, ref. 17c does not apply here.]

¶ (Insert B here)
~~A similar situation exists as to chronic obstructive pulmonary disease (COPD), principally bronchitis and emphysema. No one seriously~~ *claims have been made*
~~phoric tobacco smoke causes such diseases in nonsmokers. However, it is frequently claimed by some usually the same vocal minority who make assertions about cardiovascular disease and cancer that parental smoking causes respiratory illness in children.~~ *chronic obstructive pulmonary disease (COPD) and other respiratory diseases in nonsmokers.*
Those making this claim point to various questionnaire-type studies by Colley and others,¹⁸ which report that children of smoking parents have an increased incidence of respiratory illness compared to children of nonsmoking parents. They cite these studies

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as proof of their theory, even though some of these studies also find a correlation between respiratory illness in the parents and similar such illnesses in the children, irrespective of smoking. Thus, the question recognized by Colley himself of whether the children's respiratory illness is caused by cross-infection from the parents or by a genetic predisposition to such illnesses in both parents and children,¹⁹ is simply ignored by those who argue that smoking is the established cause of the reported respiratory illness in these children. Likewise, they ignore other studies, including one by the Environmental Protection Agency, *and another from the Harvard School of Public Health,* that do not find such an association.²⁰ For them, the parts of the questionnaire-type studies that appear to support their position settle the issue.

co-authored
~~Recently, a study~~²¹~~by Bouhuys--an avowed critic~~
of smoking--and coworkers reported data that parental smoking does not cause respiratory illness in children or other family members. These researchers studied respiratory symptoms, diseases and lung function in 376 families with 816 children in three towns and "found no significant relation between parent smoking and respiratory symptoms or lung function in their children." They concluded "that exposure to low levels of smoke produced by cigarette smokers does not result in chronic respiratory symptoms or loss of lung function among children nor among adults."

Another recently reported clinical study by Kerrebijn, et al., on chronic nonspecific respiratory diseases in children confirms the findings of Bouhuys, et al. Their study found that

"Smoking and nonsmoking parents have about the same proportion of children with respiratory symptoms. The number of cigarettes smoked by the parents has no influence on respiratory symptoms in their children. . ."²²

Quite apart from disease causation, questions have been raised about whether there exists a small group of extremely sensitive or otherwise ill persons whose conditions might be exacerbated by atmospheric tobacco smoke. For example, former Surgeon General Luther Terry, after discounting the causation of disease in nonsmokers, stated that "there are a few people who are genuinely sensitive, allergic to tobacco smoke and who can be made ill by being exposed to tobacco smoke."²³

[Document:
Taylor] Contrary to Dr. Terry's belief, the question whether cigarette smoke, or any of its constituents as found in smoke, is a respiratory tract allergen is unresolved.^{cite} Claims about tobacco allergy stem primarily from the many studies that have been done over a long period of time in which extract from tobacco leaf has been tested and found to cause allergic response usually in ^{some} people--both smokers and nonsmokers--who are otherwise allergic.²⁴

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Document: However, studies with tobacco leaf extract do not resolve
Rylander the issue of whether cigarette smoke or any of its constitu-
Footnote ents is allergenic. One recent study reported the [isolation
[Consider → of a large molecular weight molecule] from tobacco smoke,
Simplifying] which the authors claim to be an allergen.²⁵ However, Dr.

Gerald Gleich of the Mayo Clinic reported to the American Academy of Allergy, as recently as 1976, that he and his colleagues had failed to find any evidence of tobacco smoke allergens in their tests of 30 subjects who reportedly experienced allergic type symptoms on exposure to tobacco or tobacco smoke.²⁶ Dr. Gleich, as well as Dr. John Salvaggio and coworkers at Tulane University, are currently doing scientific research in this area. Their work to date has not found any allergens in tobacco smoke. *

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Another group believed to be particularly vulnerable to various environmental impingements, including tobacco smoke, are asthmatics. This belief is based on several subjective reports that asthmatics are bothered by such smoke. However, there are ^{findings} no objective evidence to support these reports. ^{Spitzer, et al. did not find, for example, any connection between} And, one recent study by Pimm, et al., failed to find any significant changes in the lung function of asthmatics who had been exposed to cigarette smoke in a small test chamber.²⁷ Further research is also needed in this area.

parental smoking
and the incidence
of asthma in
their offspring.

✓ ^{Assertions have been made that}
persons with severely compromised cardiovascular systems are ~~another group believed to be~~ adversely affected by environmental tobacco smoke, especially carbon monoxide

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✓ whatever its source. This belief stems largely from Aronow's studies of angina patients in which he used "pure" carbon monoxide, as well as tobacco smoke, to elevate their COHb* levels. He found that a certain COHb level obtained by exposure to "pure" carbon monoxide caused certain changes in cardiac function, but that the same COHb level obtained from tobacco smoking did not result in such changes.²⁸ The reason for these differences in cardiovascular function are as yet unknown. Whatever the reason for these findings, this study raises a substantial question about the relevancy of "pure" carbon monoxide type studies to the nonsmokers' situation. This is another area where further research is needed.

Aside from matters of disease causation and persons who are either extremely sensitive or otherwise ill, there is a small group of nonsmokers who overreact strongly to the presence of tobacco smoke in the atmosphere. Here the question is whether there are sufficient amounts of atmospheric smoke to account for this phenomenon on a physiological basis, or, whether the overreaction of this small group of nonsmokers is better explained in psychological terms. The slightest smell of tobacco smoke causes them to overreact, even though the atmospheric levels

*COHb is the combination formed by carbon monoxide and red blood pigment.

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(NOTE: THIS COPY WAS SLANTED LIKE THIS ALSO.)
of such smoke are generally "much lower than assumed by convinced nonsmokers," as recently noted by Professor G. Wagner of the German Cancer Research Center.²⁹

✓ To support their claims, the overreactors cite laboratory studies ^(Insert C here) ~~reporting that high concentrations of tobacco smoke can be irritating and, therefore, produce various respiratory and other symptoms. These symptoms, however, are usually alleviated shortly after the smoke is removed.~~ As a practical matter, however, it has been observed that when the concentration of smoke sufficient to produce such ^{annoyance} ~~symptoms~~ is reached in real-life situations, persons respond appropriately, e.g. they may either quit smoking or open a window.³⁰

Studies have measured tobacco smoke constituents in the atmosphere under realistic conditions; these have not found levels sufficiently high to account for ~~the overreaction of this small group of nonsmokers.~~ Instead, these studies indicate that under realistic conditions, indoor atmospheres do not normally have high concentrations of tobacco smoke constituents. For example, there have been a considerable number of studies on carbon monoxide in the atmosphere from smoking. The combined results of these studies indicate that under realistic conditions carbon monoxide in the atmosphere from smoking will rarely exceed 10 parts per million (ppm).³¹

One exception was reported in a study of a

sports arena which permitted smoking but was not air conditioned. There the carbon monoxide (CO) level reached 25 ppm.³² Another exception was the studies performed in taverns and night clubs where CO levels as high as 42 ppm were recorded.³³ It should be noted, however, that these studies were performed with an instrument known to exaggerate the level of CO in the presence of alcohol vapors.³⁴ Moreover, all of the values obtained in real-life situations are below 50 ppm, which is the level set by various health administrations (e.g. U. S. Occupational Safety and Health Administration) as the limit for industrial exposure over an 8-hour period.

*Note:
European
(Herman MAK)
standards
more appropriate
for this paper.*

Many studies have measured COHb levels in smokers and in nonsmokers exposed to tobacco smoke. Other studies have observed COHb levels in persons exposed to carbon monoxide not derived from cigarette smoke. The combined results of these studies indicate that under realistic conditions smokers will rarely experience COHb levels greater than 10% and that nonsmokers will not usually exceed 2 to 3%. And, even these relatively low levels of COHb will drop within a few hours after the cessation of exposure to smoke.³⁵

The scientific studies notwithstanding, the antismokers continue to complain about the alleged build-up of carbon monoxide in offices and other places where smoking is allowed. One recent study showed that the

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COHb levels of office workers were higher when they came to work than when they left at the end of the day, even though they were exposed to cigarette smoke throughout the day.³⁶ The results of this study indicate that the antismokers should be more concerned about the outdoor levels of CO from car exhaust and other sources that non-smokers are exposed to on their way to work than tobacco smoke in the office.

✓ It should be noted that no one has ever established that the health of ^{normal} nonsmokers is adversely affected by even the small amount of CO that might be in the atmosphere as a result of cigarette smoke. CO is a natural body constituent which is even present in very small quantities in the blood without any exposure to CO in the atmosphere. The body can and does get rid of CO by various means. And, it should be noted, persons with COHb levels of 15% or less rarely even suffer any of the first symptoms of CO difficulties, such as headache, ^{or} nausea, ^{etc.} ~~etc.~~³⁷

✓ One claim that is frequently made about exposure to low levels of CO is that it affects certain performances, such as ability to distinguish between short intervals of time and to solve mathematical problems. There is still disagreement in the scientific literature, however, as to whether such performances are affected by COHb measurements in the neighborhood of 10% or less. Some studies indicate

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that these levels of CO will affect such performance,³⁸ while other studies do not so indicate.³⁹ *(Insert D here)*
~~This is another area that requires additional research.~~

In contrast to studies performed under realistic conditions, the ~~overreactors~~ *anti-smokers* frequently cite studies conducted under highly artificial situations as evidence that high concentrations of CO from cigarette smoke can be attained. One such study by Srch placed two smokers and two nonsmokers in a small closed car *side closed* in a garage and had the smokers smoke ten cigarettes in one hour.⁴⁰ Another study by Harke placed a European car in a wind tunnel and then had nine cigarettes smoked inside the car, one after another, without any ventilation in the car and no outside wind movement.⁴¹ Of course, in situations such as these, a rapid buildup of CO occurs; however, as Doctor Harke observed, these conditions do "not correspond to a normal traffic situation." And the subjective reactions of the test subjects to the increased levels of smoke concentration were revealing:

"... a threshold is reached at roughly 20 ppm [of CO] which normally prompts one to open a window or to turn on the ventilation."

Studies on nicotine indicate that atmospheric levels are minimal.⁴² No one has suggested that the minuscule amount of nicotine that might be absorbed by a nonsmoker has anything to do with the production of human disease. Indeed one recent study that monitored heart

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rate in nonsmokers exposed to cigarette smoke under laboratory conditions concluded that the amount of nicotine inhaled by nonsmokers under their rigorous test conditions was too small to alter heart rate.⁴³

✓ Studies of other tobacco smoke constituents indicate that smoke's contribution to atmospheric levels of these compounds is minimal.⁴⁴ These studies are usually conducted in the context of an exaggerated claim about the danger of exposure to some compound attributable to tobacco smoke. One such study of "volatile" organic compounds recently concluded that the amount of such compounds added to the atmosphere as a result of cigarette smoking is "insignificant."⁴⁵

[Is this
privileged
information?
Brunnemann
status?]

The laboratory measurement of smoke constituents often is done as a purely analytic study without taking account of real life situations. [A current example is Dr. Brunnemann's recent report of nitrosamines in tobacco smoke.⁴⁶ In presenting and discussing his findings during a meeting in Germany,^{*47} Dr. Brunnemann stated that his study was intended as a model study and not as an imitation of reality.]

Because the overreaction of some nonsmokers to smoking cannot be explained on the basis of a physiological response to atmospheric tobacco smoke or any of its constituents, the question arises whether this reaction can be explained on an emotional basis. While this question

*Please note restriction on use in Footnote 47.

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is far from settled, at least one researcher, Dr. Gary Huber, has suggested that this might be the case, noting that the odor of smoke components "may trigger emotional responses not yet well understood."⁴⁸ This theory finds some support in a recent study by Rummel, et al.,⁴⁹ in which college students, who were first characterized as to their attitudes concerning tobacco smoke, were exposed to such smoke. The authors reported a significant difference in heart rates of those who "disliked" smoke compared with those who were "indifferent" to smoke, with the higher rates among those who "disliked" the smoke. The authors could not determine from the data whether the "dislike" group had a true higher heart rate initially, or whether the anticipation of sitting and inhaling the "disliked" cigarette smoke caused an increased heart rate.

This is not to say that perfectly normal people are not sometimes annoyed or irritated by atmospheric tobacco smoke. Especially in places that are poorly ventilated, concentrations of atmospheric tobacco smoke may themselves or in combination with other environmental influences give rise to eye or nasal irritation.

✓ *normal*
Whatever the basis of the overreaction of some nonsmokers to smoking, one thing is clear: atmospheric tobacco smoke has not been proven hazardous to the health of nonsmokers. Accordingly, as Dr. Pimm noted in connection with his research on asthmatics exposed to tobacco

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smoke, if smoking is to be restricted, it will have to be on the basis of annoyance and visual disturbance and not on health grounds.⁵⁰

III. Government Regulations and Individual Rights

✓ While common sense dictates no smoking for safety reasons in certain instances (e.g. near ~~gasoline~~ *petrol* pumps), measures against public smoking, based upon unfounded claims that tobacco smoke causes disease in the nonsmoker, are unjustified. Beyond this, for government to regulate smoking in public or other places because it may annoy or irritate some nonsmokers constitutes an unwarranted intrusion into people's private lives.

Contrary to the claims of the antismoking leaders, the vast majority of people--smokers and nonsmokers--are not usually annoyed by public smoking. For example, a recent U. S. survey found that when people were asked about the kinds of things that annoyed or irritated them in their everyday lives, only about 2% of the annoyances mentioned were related to smoking.⁵¹ ~~Indeed~~ ✓ ~~91% of those in the survey didn't even mention smoking.~~⁵²

The American Express Company found little interest in nonsmoking tours that they sponsored.⁵³ Numerous surveys demonstrate that diners have little or no interest in the nonsmoking sections of restaurants. For example, one Seattle, Washington restaurant reported that in a 3-month period in which the restaurant had served

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30,000 customers, there were only seven requests for seating in the nonsmoking area.⁵⁴

✓ Why then this outcry about public smoking by a small but vocal minority of antismoking leaders?

They claim to seek protection for the nonsmoker, but their real aim is to harass and curtail the rights of smokers.

As stated at the 3rd World Conference on Smoking and Health in response to a question:

"... and of even more consequence, is what nonsmokers' social action can contribute to the solution of the total smoking problem and its devastating effects on smokers."⁵⁵

A campaign to harass and otherwise inhibit smokers is not a legitimate concern of government.

✓ ✓ Public smoking policy should be set in light of the facts, not upon ~~unfounded health~~ ^{proven} claims that atmospheric tobacco smoke ^{causes disease in} ~~is harmful to~~ nonsmokers.

✓ In any event, the antismokers are sometimes successful. They get laws and other regulations ^{adopted} ~~to ban~~ or limit the rights of smokers, but at a high cost to society. Thousands of hours of time are spent on an issue that is of little real consequence. Moreover, the end results of these costly proceedings are laws and regulations that are frequently impractical and unenforceable.

Laws and other regulations that ban or limit

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smoking, whether aimed at the smoker or the nonsmoker, constitute an unwarranted intrusion into the lives and rights of citizens. People in a free society should be allowed to make informed choices about smoking.

Nor can these laws and other regulations be justified on the basis of annoyance to nonsmokers. If the problem is one of annoyance, it can best be dealt with by mutual courtesy between smokers and nonsmokers rather than by governmental regulation or deprivation of individual freedom.

IV. Future Action by the Tobacco Industry

✓
✓ In order to understand why public smoking has developed into a public issue when there is no real basis for public actions[?], when there are not ~~real~~ public interests involved and when public actions[?] infringe on private rights (freedom), the tobacco industry proposes the following actions:

1. Social science research programs:

- (i) What causes nonsmokers to accept unsubstantiated accusations about public smoking.
- (ii) What is the depth and extent of opinion and feeling about smoking as a public annoyance.
- (iii) Is the public smoking issue part of a broader range of social issues of which cigarette smoking is currently the most visible.

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2. Medical science research programs directed toward:

- (i) Determining whether or not there are any groups of extremely sensitive or otherwise ill people whose conditions may be exacerbated by various environmental influences, including tobacco smoke.
- (ii) Investigating any evidence asserting that public smoking causes disease in these or any other groups.
- (iii) Determining why certain nonsmokers overreact to even small amounts of tobacco smoke in the atmosphere.

3. Public information programs:

- (i) To inform the smoking and nonsmoking public of the truth about tobacco smoke in the atmosphere and health.
- (ii) To urge smokers and nonsmokers to be mutually courteous.
- ✓ (iii) To cooperate in public safety programs that encourage awareness of possible fire hazards.

Beyond these research and information programs, the tobacco industry will strengthen its activities in support of legislative freedom of smokers and nonsmokers alike.

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[Reconsidered using this reference]

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INSERT A:

In 1977, Dr. Astrup et al. reinvestigated the effects of CO exposure in rabbits and found no increased arterial changes between the exposed and nonexposed animals. In explaining the findings, the authors wrote that the "present study suggests

. . .

INSERT B:

Also at variance from the earlier Astrup findings are the observations in bridge and tunnel workers indicating that persons chronically exposed to high levels of carbon monoxide do not have any increased incidence of atherosclerosis.

INSERT C:

in which there was no ventilation and large numbers of cigarettes were smoked in a relatively short period of time. Naturally, under such unrealistic conditions, many odors including tobacco smoke can be annoying.

INSERT D:

That this is another area which requires additional research was recognized by the Federal Aviation Administration (U.S.A.) recently when it denied the petition of several anti-smoking groups who had sought to prohibit smoking by airline pilots. Air Force scientists found no impairment in performance either at the low levels of exposure that occur when tobacco is smoked or at much higher exposures. The decision states that the existing data are "too inconclusive to warrant the issuance of the requested rule at this time."

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