MINUTES OF THE HUMAN SERVICES COMMITTEE
February 20, 1981

The Human Services Committee convened at 11:45 a.m. in Room 103 of the Capitol on February 20, 1981 with CHAIRMAN BUDD GOULD presiding. All members were present except REP. BARDANOUVE who was excused.

HB 794
The hearing on HB 794 was opened by REP. ELLERD, sponsor of the bill. This bill relates to clean air in public places, (regarding smoking) and enforcement of the act. He asked Vern Sloulin to explain the present status of the law.

VERNON SLOULIN, DHES, testified that posters specifying "smoking" and "no smoking" and information about the laws have been printed and distributed at a cost of about $5,000. Inspections have been made and time to explain the law also have been spent to carry out the existing bill. He stated that many owners of public establishments have refused to post signs, causing a problem in enforcing the law.

PROPONENTS:
DOUG OLSON, attorney for the DHES, said he had received a number of requests relative to the enforcement of the Montana Clean Air Act. If the Legislature intended to enforce the act, he said, this bill will help the DHES to do so. He submitted to the committee a copy of a recent article, published by the Missouri Law Review that attempts to delineate the smoking laws and ordinances throughout the country. (EXHIBIT I)

STEVE BALAZS, representing the Montana Lung Association, presented written testimony in favor of HB 794. (EXHIBIT II)

PASTOR GARY JENSEN, of Helena, who conducts non-smoking clinics throughout the state, said that complains are frequent and he felt that some way of enforcing the law was necessary. Enforcement officers have their hands tied as provisions for enforcing the law are not provided, he said. He read part of an ordinance from San Diego, which told that fines were levied. He felt that this bill was a very reasonable way to enforce the law.

JERRY LOENDORF, lobbyist for the Montana Medical Association, testified in favor of the bill.

OPPONENTS:

DON W. LARSON, Helena, lobbyist for the Montana Tavern Association, and Jorgenson's Holiday Inn, appeared in opposition to the bill, because it infringes on the rights of his customers. He said the law exempts taverns, but he has both a bar and restaurant. Some people like to eat lunch in the bar, and he said this law would prevent them from doing that. He proposed that an interpretation of DHES, which told him his bar was exempt be added to change this bill. He said that every facility has its own problems and should be inspected in regard to this law.

Bill KUNEY, manager of the Colonial Inn,in Helena, pointed out difficulties that his business would have in complying with this law. He said that his convention center area is changed from large to small rooms constantly, and that oversights in changing the non-smoking signs are likely to happen. He felt he would lose business if forced to comply with this proposed law.

BOB DURKEE, Montana Tavern Association, opposes the bill, but would concur with the amendment suggested by DON LARSON. He feels the bill would pit neighbor against neighbor, and open the door to a great many complaints to be resolved.

QUESTIONS FROM THE COMMITTEE:

REP. PAVLOVICH asked the sponsor about the fines. REP. ELLERD said he would be willing to work out any problem in that regard.

REP. KEYSER said he felt the bill allowed each city to interpret the bill individually and thought this would be a problem. REP. ELLERD said the bill was open to amendment. He also said the intent of the Clean Air Act was to let people know whether or not smoking was allowed in an area, as some people have health problems and should avoid smoke.

REP. ELLERD closed the hearing on the bill.

HJR 36.

REP. ELLERD opened the hearing on the resolution which urges the President of the United States to call attention to the plight of prisoners of war in any declaration concerning Veterans' Day.

PROPONENTS:

BO DURKEE, representing veterans, said there are still over 2,500 MIAs from the Viet Nam War. Fourteen of them have not been declared dead and the government is still trying to locate them. He hopes this resolution will help this matter.

TONY CUMMING, state adjutant of the American Legion went on record as favoring the resolution. He gave the committee a copy of Action, a Veterans of Foreign Wars publication. (EXHIBIT III)

OPPONENTS:

There were none.

QUESTIONS FROM THE COMMITTEE:

There were none.

CHAIRMAN GOULD asked the committee to act upon this resolution.

EXECUTIVE SESSION:

REP. BERGENE moved that HJR 36 DO PASS. The motion was seconded and PASSED UNANIMOUSLY.

HEARINGS were then resumed.

HB 764

REP. VINGER opened the hearing on HB764. The purpose of the bill is to establish a Montana emergency medical services system, including training and support for emergency care providers; to provide for a state EMS advisory council and regional EMS entities. He read the Statement of Intent. He told the committee that the Fiscal Note was attached and that the appropriation to fund this would be $1.5 million.

PROPONENTS:

KEATHA MC LEOD, a nurse from Baker, Montana, appeared as a proponent. (EXHIBIT V).
NORMAN DEWELL, Joliet, presented written testimony in favor of the bill (EXHIBIT VI). He also submitted about 30 letters written by people in Carbon County supporting HB764. (EXHIBIT VII)

ART BICSAK, Great Falls, president of the Montana Energency Medical Services Association (MEMSA), presented comments of the MEMSA Legislative Committee, concerning the utilization of Federal funding within Montana. (EXHIBIT VIII). He also proposed amendments. (EXHIBIT IX).

Dr. ROBERT SHEPARD presented written testimony (EXHIBIT IX A).

DR. KETZELMAN, asked to be on the record as a proponent.

OPPONENTS:

WILLIAM MURRAY Coordinator of Cascade County Civil Defense in Great Falls, feels that there are serious difficulties with the bill, and felt it could bring to an end the EMT service in Montana. He presented statistics supporting his opinion (EXHIBITS X and XI), and written testimony (EXHIBIT XII).

LINDA ZEISING, Whitehall EMT, stated disagreement with several provisions of the bill and presented a letter from GAIL GIONO who also urged defeat of the bill. (EXHIBIT XIII).

KEN. RUTLEDGE, representing the Montana Hospital Association, testified in opposition to the bill.

JOHN BAINES, an EMT from Helena, opposed the bill in its present form and suggested several amendments.

CAPT. WALT MILLER, Montana Highway Department, feels this bill gives a lot of control to the EMS program. He stated that the MHP has its own training program now and, under this law, MHP would fall under EMT regulations. He felt these requirements would create problems for the MHP.

LLOYD LINDEN, Helena ambulance service owner, opposed several provisions of the bill.

QUESTIONS:

REP. SEIFERT asked if the present program is in existence under a present law. REP. VINGER said the bill is to provide state funds to provide the training for the present program.

REP. SEIFERT asked if a 21-member board might not be a little large. KEATHA MCLEOD felt that a large state such as Montana needed a large board so that there would be a great amount of input.

REP. WINSLOW asked for more information about the scheduled training sessions. BAINES said that advanced first aid is given by the Red Cross. The training an EMT receives is over 100 hours and is a more in depth training, yet under Montana law, can do no more than a person who has Red Cross first aid training.

REP. WINSLOW asked if it wouldn't be more feasible and less expensive to add staff at the state level. DEWELL said that was possible, but he felt that the ability to reach all the EMTs would be less than under the provisions of the bill.

REP. NILSON asked what would happen if this bill didn't pass. In regard to the training of EMTs. REP. VINGER said there would be no training at the state level, because there would be no money to fund it.

REP. PAVLOVICH referred to page 5, section 5 and asked if the local governments shouldn't be advised of the rules contained in the bill. REP. VINGER said he felt they will be. MC LEOD said the advisory council would do that as they would be at the "grass roots" level.

REP. BERGENE commented that Mr. Murray has stated that the Advisory Council could complain but that they had no control over funds (or power to make changes). MC LEOD said the county would have the council for input as to how to spend the funds. All counties would have representation on the council.

MURRAY said he has 13 years of dealing with the EMT program, and 6 years of dealings with the structure proposed by this bill. He said that many good programs have gone on and will continue to do so. He agreed that the counties have not had a voice in the program. The programs are run by non-profit corporations run under the laws of the state covering non-profit corporations, not laws covering expenditures of tax funds governed by officials.

REP. KEYSER asked why the directors of the department would appoint the board (council). MC LEOD said they used the protocol that was standard in setting up a Governor's advisory committee.

REP. KEYSER asked why the bill didn't include an exclusion for the Montana Highway Patrol. DR. SHEPHERD said the statement of intent clearly states that there will be no duplication of services. He said that, with all due respect to the Highway Patrol, even they should have some overview as to the content and training that the patrolmen receive. They, as well as firemen and police departments. Physicians should be allowed to give input as to the training given.

REP. SWITZER wondered if there was any assurance that the department would pay any attention to the advisory council. MC LEOD said that with 21 people on the council, there would be some political clout, and response to problems.

REP. VINGER said his intent was to bring further education to all levels of EMTs. He then closed the hearing on SB764.

HB797.

REP. BENNETT opened the hearing on HB 797 proposing the sale of DMSO under certain guidelines.

PROPONENTS:

DR. JOHN SHALLENBARGER, a Urologist, testified that DMSO could help many patients. He said it is available to some, but not all who could benefit from its use and that it is not free from contaminants. Trainers are using it and many others are getting it on the black market. He said it was dangerous when given to rats in large doses (in research), and was thus restricted, but that it is a very helpful drug when given correctly in many instances including urinary tract, skin problems and arthritis. He recommended that physicians be allowed to prescribe the drug, but felt it shouldn't be sold over the counter.

FRANK DAVIS, Executive director for the Montana Pharmacy Association, said he agrees with Dr. Shallenbarger that DMSO use should be allowed, but his main concern was the type of drug allowed and felt that should be stated clearly. He read a suggested amendment. Page 3, line 11 Insert: "pharmacy or employee thereof"

OPPONENTS: There were none.

QUESTIONS:

CHAIRMAN GOULD asked if DMSO was legalized, where would we get it as it's not manufactured in Montana. DR. SHALLENBARGER said that he hoped it would be produced here, so Montana physicians wouldn't be in conflict with the law which states that it is illegal to transport the drug across state lines. RIMSO-50 is available to physicians and is approved by the FDA and legal for interstate transportation.

REP. MENAHAN asked if RIMSO-50 was the purified form of DMSO. DR. SHALLENBARGER said Yes.

REP. MENAHAN asked if we could buy it now. DAVIS said yes, under prescription, but that the only approved use was for interstitial cystitis. DR. SHALLENBARGER said that there are various strengths of DMSO. He said that RIMSO-50 was a 50% solution and commented that it is sometimes used for skin problems, used by placing it on Saran wrap which is directly on the skin. (That, apparently is legal.)

REP. MANNING asked if this was the same drug as is used on the race tracks. DR. SHALLENBARGER said that was the veterinary (type). He didn't know where it was purchased. CHAIRMAN GOULD commented that it was legal to use it for veterinary purposes. He also said that it is used extensively for cleaning farm machinery.

REP. BRAND asked VERN SLOULIN of the DHES about the availability of DMSO. SLOULIN said it is being sold in the bars and the filling stations and it is thought to be of the "degreaser" quality. It

is bought for $77.00 for 55 gallons, and then it is sold for $20.00 for 6 oz's.

REP. BENNETT closed the hearing on the bill.

HB 734.

REP. WINSLOW opened the hearing on the bill. It is an act to waive state inspection for health care facilities that are accredited by the joint commission on accrediation. He said it is to remove a duplication of accreditation.

PROPONENTS:

BILL LEARY of the Montana Hospital Association, presented written testimony and suggested amendments (EXHIBIT XIV).

JO ANN DODD, of the Montana Nurses Association, sent written testimony to be entered into the record through Mr. Leary, urging support for the bill.

OPPONENTS:

JACQUELINE MC KNIGHT, of the Department of Health and Environmental Sciences (DHES) presented written testimoney. (EXHIBIT XVI). She said the DHES proposes amendments to HB 734 and read them (see page 2 of EXHIBIT XVI).

QUESTIONS FROM THE COMMITTEE:

REP. WINSLOW asked if cooperation has worked in other states between the JOINT Commission on Accreditation of Hospitals (JCAH) and the state governments. BILL LEARY said "yes" and read a portion of the Texas law. He said that many states have this agreement.

REP. METCALF asked if the MHA disagreed with the amendments proposed by the DHES. LEARY said they would oppose the "2 year" amendment.

REP. WINSLOW closed the hearing on HB 734.

HB 735.

REP. WINSLOW opened the hearing on HB735, saying it was similar to HB 734 but that it pertained to the licensing of laboratories.

PROPONENTS:

WILLIAM LEARY, MHA, testified in favor of the bill. He also proposed an amendment to provide application only to those clinical laboratories operated by a licensed Montana hospital. (EXHIBIT XVII).

JERRY LOENDORF, representing the Montana Medical Association, appeared in favor of the bill.

OPPONENTS:

JACQUELINE MC KNIGHT, representing the DHES, read written testimony in opposition to the bill. (EXHIBIT XVIII)

QUESTIONS BY THE COMMITTEE:

REP. METCALF wondered if there was a conflict between HB 734 and HB 735. LEARY said there was none.

REP. WINSLOW said that the hospitals are not requesting relief from high standards but only ask relief from duplication which results in higher costs for the hospitals and the patients. He then closed the hearing on HB735.

HB 784.

REP. DOZIER, appearing for REP. TEAGUE, opened the hearing on HB784, which would assign a Hispanic Liaison to the State Department of Rehabilitation Services to work with Hispanic organizations.

PROPONENTS:

ROBERT FEDERICO thanked the committee for their DO PASS recommendations on the previous HJRs regarding the Hispanic population of Montana. He urged the committee to continue to help the Hispanics by passing HB 784.

OPPONENTS: There were none.

QUESTIONS FROM THE COMMITTEE:

REP. SWITZER asked if this would conflict with the HJR regarding an ombudsman for the Hispanics. REP. DOZIER said he felt it would not, that the ombudsman would be working out of the Governor's office.

REP. DOZIER closed the hearing on HB 784.

HJR 39.

REP. DOZIER opened the hearing on HJR 39, which is to urge the state to participate in a cultural heritage coordination with the federally designated week honoring the Hispanic culture.

PROPONENTS:

ROBERT FEDERICO, Billings, urged support of HJR 39.
MARGE OROZCO testified that she helped organize the Spanish Heritage week in Billings. She said that it was a success that the state could enjoy if it were proclaimed statewide.

OPPONENTS: There were none.

EXECUTIVE SESSION.

HB 794.

CHAIRMAN GOULD moved that HB 794 DO NOT PASS, stating that he felt criminal penalties should not be imposed. The motion was seconded and PASSED with REP. SWITZER, CONN, WINSLOW, NILSON and METCALF voting NO.

HB 764.

REP. NILSON MOVED for a DO PASS on HB 764. REP. METCALF MOVED the amendments be accepted by the committee. RUSS JOSEPHSON read the amendments, which added board members-at-large and included the Hospital Association people. The amendments PASSED with REP. SWITZER, PAVLOVIC and DEVLIN opposing.

REP. KEYSER MOVED an amendment as follows: Page 5, line 17, following [section 5[, insert: ", except that the EMS advisory council may not control the Montana highway patrol first-responder program." The motion was seconded and PASSED UNANIMOUSLY.

REP. METCALF MOVED that the Statement of Intent be accepted and that the bill DO PASS AS AMENDED. RUSS JOSEPHSON gave a clarification of the Statement, saying that the bill applies to more than the EMT program. The Statement of Intent was seconded and PASSED UNANIMOUSLY.

The bill as amended PASSED by a vote of 9 YES votes with 6 committee members voting NO. The NO votes were cast by REP. DEVLIN, SWITZER, PAVLOVICH, SEIFERT, SIVERTSEN and BENNETT.

HB 797.

REP. BENNETT MOVED an amendment as follows: on page 3, line 12, following: "facility," Insert: "pharmacy," and AS AMENDED DO PASS. The MOTION WAS SECONDED AND CARRIED UNANIMOUSLY.

HB734.

REP. WINSLOW moved the bill be amended as suggested by Bill Leary of the Montana Hospital Association. The amendments were seconded and PASSED UNANIMOUSLY. REP. MANNING moved that HB 734 DO PASS AS AMENDED. The MOTION CARRIED UNANIMOUSLY.

HB 735.

REP. SEIFERT moved for a DO PASS on amendments on page 9, line 3 as follows: Insert: "NEW SECTION. Section 3. [Section 2] applies only to those clinical laboratories operated by a hospital licensed by Montana." REP. SEIFERT MOVED the bill DO PASS as AMENDED. THE MOTION CARRIED UNANIMOUSLY.

HB 784.

REP. MANNING moved DO PASS on HB 784. REP. SWITZER stated he felt that the legislation was not necessary, and that the SRS should take care of acting as liaison between the Hispanics and REP. KEYSER moved HB 784 DO NOT PASS. The motion failed by a vote of 8 to 8. REP. MANNING moved that HB784 BE TABLED. The motion was seconded and CARRIED with REP. CONN voting NO.

HJR 39.

REP. SEIFERT moved that HJR 39 DO NOT PASS. The motion was seconded and FAILED by a vote of 8 to 8. REP. METCALF MOVED that HJR 39 be TABLED. The motion passed UNANIMOUSLY.

HB755.

REP. MENAHAN moved that HB 755 DO NOT PASS.

REP. SIVERTSEN moved a SUBSTITUTE MOTION that HB 755 DO PASS. He briefly spoke in favor of the bill. The motion was seconded and PASSED by a VOTE of 11 to 4, the NO votes being REP. WINSLOW, KEYSER, PAVLOVICH and MENAHAN.

HB 514.

REP. MANNING MOVED that HB 514 be taken off the table and RE-CONSIDERED. The motion CARRIED, OPPOSED by REP. WINSLOW.

REP. MANNING moved for a DO PASS ON HB 514. REP. DUSSAULT presented amendments to the committee for consideration (EXHIBIT XIX), explaining that they change reference to licensing and certification

among other provisions. After further discussion REP. NILSON MOVED the AMENDMENTS. The motion CARRIED. REP. NILSON MOVED that HB514 DO PASS AS AMENDED. The motion was seconded and FAILED by a vote of 8 NO to 7 YES.

CHAIRMAN GOULD MOVED THAT THE MOTION AND THE VOTE BE REVERSED. That motion was seconded and PASSED. THE recorded motion for HB 514 is DO NOT PASS AS AMENDED with the NO VOTES recorded as follows: REPRESENTATIVES GOULD, BERGENE, CONN, MANNING, METCALF, NILSON AND MANNING.

CHAIRMAN BUDD GOULD

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VISITORS' REGISTER

HOUSE Human Services COMMITTEE

BILL [illegible] Date 2-20-81

SPONSOR [illegible]

NAME	RESIDENCE	REPRESENTING	SUP-PORT	OP-POSE
Gaylon B Olson	Helena	DHES	✓	
Steve BALAZS	"	Montana Lung Assn.	✓	
Anna B. Jones	"	" " "	✓	
Kenor Sloan	"	DHES	✓	
Pastor Gary Jones	"	Self	✓	
D.W. Karren	"	M.T.A & Self		✓
Bob Durkee	"	M.T.A		✓
Bill Kenney	"	Self - MTA		✓
Janelle Fallan	-	Montana Chamber		—
Kyle Hom				
Brian Ents	Helena	Mt. Med. Assn	✓	
JT Lowney	"	" " "	✓	
David Mangan	Helena, Mt.	self and family	✓	

IF YOU CARE TO WRITE COMMENTS, ASK SECRETARY FOR LONGER FORM.

PLEASE LEAVE PREPARED STATEMENT WITH SECRETARY.

Form CS-33
1-81

THE LEGAL CONFLICT BETWEEN SMOKERS AND NONSMOKERS: THE MAJESTIC VICE VERSUS THE RIGHT TO CLEAN AIR

I. Introduction

Ever since the First World War, cigarette smoking has been a popular habit in the United States.[1] As recently as 1966, 42% of the adults in the United States smoked,[2] and in 1978 an estimated 54 million Americans smoked 615 billion cigarettes.[3] During the last sixteen years, however, the popularity of tobacco smoking has suffered some severe jolts. In 1964, the Surgeon General determined that cigarette smoking was hazardous to the health of the smoker and proclaimed it a health hazard of sufficient magnitude to warrant remedial action.[4] The 1972 Surgeon General's report announced that cigarette smoking was not only dangerous to the smoker,

1. S. Wagner, Cigarette Country: Tobacco in American History and Politics 36-44 (1971). The ambivalent public attitude toward smoking is reflected by Mark Twain's description of smoking as "The Majestic Vice." S. Clemens, The Adventures of Tom Sawyer 114 (1963).

2. Public Health Service, U.S. Department of Health, Education and Welfare, Smoking and Health vii (1979) [hereinafter cited as 1979 Report]. The percentage has since dropped to 33%. *Id.*

3. *Id.*

4. Public Health Service, U.S. Department of Health, Education and Welfare, Smoking and Health 33 (1964) [hereinafter cited as 1964 Report].

but probably dangerous to the people around him, too.[5] The 1975 and 1979 reports confirmed this finding.[6]

As the dangers of smoking have become more understood, several measures have been taken to protect people who choose not to smoke from those who smoke: states have enacted statutes;[7] cities have passed ordinances;[8] federal legislation has been suggested and, in some cases, implemented;[9] constitutional arguments have been formulated;[10] common law protections have found new application;[11] and, familiar tort theories have been considered.[12] The purpose of this Comment is to analyze the legal conflict between smokers and nonsmokers with special emphasis upon the legal remedies that exist for the nonsmoker who cares enough about his rights to seek legal redress.

II. Early History of the Conflict Between Smokers and Nonsmokers

Although the legal battle between smokers and nonsmokers is a recent development in many ways, in some respects it is a resurrection of an earlier crusade against smokers.[13] Restrictions on smoking reached their zenith in the United States around the turn of the century. In 1901, twelve states had statutes restricting or forbidding the sale or use of cigarettes.[14] Cigarette smoking was considered reprehensible and immoral,[15] in addition to being a fire hazard.[16] The nonsmoking statutes did not remain on the books very long, though; the fiasco of prohibition turned the public mood against such absolute prohibitions and the nonsmoking statutes were repealed simultaneously with the demise of the eighteenth amendment. By 1927, all of the statutes forbidding the sale or use of cigarettes had been repealed.[17]

Between 1927 and 1964 very few smoking laws existed. In the late sixties and throughout the seventies, however, more and more studies confirmed the danger a smoking cigarette presents to nearby nonsmokers,

5. Public Health Service, U.S. Department of Health, Education and Welfare, Smoking and Health 117-35 (1972) [hereinafter cited as 1972 Report].

6. 1979 Report, *supra* note 2, ch. 11; Public Health Service, U.S. Department of Health, Education and Welfare, The Health Consequences of Smoking: A Report to the Surgeon General (1975) [hereinafter cited as 1975 Report].

7. *See* text accompanying notes 57-120 *infra*.

8. *See* text accompanying notes 121-30 *infra*.

9. *See* text accompanying notes 136-46 *infra*.

10. *See* notes 147-83 and accompanying text *infra*.

11. *See* notes 184-200 and accompanying text *infra*.

12. *See* notes 201-74 and accompanying text *infra*.

13. *See generally* S. Wagner, note 1 *supra*; Annot., 20 A.L.R. 926 (1922).

14. Comment, *The Resurgence and Validity of Antismoking Legislation*, 7 U. Cal. D.L. Rev. 167, 169 (1974) [hereinafter cited as *Antismoking Legislation*].

15. Comment, *The Non-Smoker in Public: A Review and Analysis of Non-Smokers' Rights*, 7 San Fern. V.L. Rev. 141, 148 (1979) [hereinafter cited as *Non-Smoker*].

16. *Antismoking Legislation*, *supra* note 14, at 168

17. S. Wagner, *supra* note 1, at 44; *Antismoking Legislation*, *supra* note 14, at 174.

and nonsmokers began asserting their right to safety. Anti-smoking statutes are appearing again,[18] although the modern statutes are significantly different from their predecessors. When the early laws were enacted, cigarette smoke had not been proven dangerous to humans.[19] Today that danger is widely recognized.[20] While the early statutes were enacted largely to enforce moral behavior and to prevent fire hazards,[21] the recent statutes are specifically designed to protect people from the health dangers of cigarette smoke.[22] Also, while the older statutes were aimed at prohibiting all cigarette smoking, modern statutes seek only to protect people in public places from the smoke of others.[23] The modern statutes, unlike the overbroad early laws,[24] are probably here to stay.

III. Medical Evidence on the Harm of "Involuntary Smoking"

The widely recognized dangers of tobacco smoking[25] to the smoker lend credence to Horace Greeley's definition of a cigar as "a fire at one end and a fool at the other."[26] The scientific evidence on the subject is so overwhelming that courts have taken judicial notice of "the toxic nature of cigarette smoke and its well known association with emphysema, lung cancer and heart disease."[27] In 1979, cigarette smoking was the single most

18. *See* notes 50-135 and accompanying text *infra*.

19. Speculation existed, though. The Tennessee Supreme Court had this to say about cigarettes as long ago as 1900:

> We think they are not [legitimate articles of commerce] because wholly noxious and deleterious to health. Their use is always harmful, never beneficial. They possess no virtue, but are inherently bad, and bad only. They find no true commendation for merit or usefulness in any sphere. On the contrary, they are widely condemned as pernicious altogether. Beyond question, their every tendency is towards the impairment of physical health and mental vigor. There is no proof in the record as to the character of cigarettes, yet their character is so well and so generally known to be that stated above that the courts are authorized to take judicial cognizance of the fact . . . .

Austin v. State, 101 Tenn. 563, 566, 48 S.W. 305, 306 (1898), *aff'd*, 179 U.S. 343 (1900).

20. *See* notes 25-49 and accompanying text *infra*.

21. *See* notes 15 & 16 and accompanying text *supra*.

22. *See* note 68 and accompanying text *infra*.

23. *See* note 135 and accompanying text *infra*.

24. Although a city ordinance entirely banning smoking in public streets because of the fire hazard was upheld in Commonwealth v. Thompson, 53 Mass. (12 Met.) 231 (1847), similar statutes were found too broad in Zion v. Behrens, 262 Ill. 510, 104 N.E. 836 (1914), and Hershberg v. Barbourville, 142 Ky. 60, 133 S.W. 985 (1911). For a lengthy discussion of early antismoking action, see *Anti-smoking Legislation*, *supra* note 14, at 168-75.

25. All tobacco smoking can be dangerous to involuntary smokers. (For the definition of involuntary smoking, see text accompanying note 30 *infra*.) Scientific research indicates that pipe and cigar smoke contain the same compounds found in cigarette smoke. *See generally* 1979 Report, *supra* note 2, ch. 13. When the phrase "cigarette smoking" is used in this Comment, cigars and pipes are also included.

26. S. Wagner, *supra* note 1, at 31.

27. Shimp v. New Jersey Bell Tel. Co., 145 N.J. Super. 516, 527, 368 A.2d 408, 414 (App. Div. 1976). *Accord*, 29 Am. Jur. 2d *Evidence* § 120 (1967) (citing four cases). Several legislatures have specifically recognized the danger of cigarette smoke. *See* notes 66-68 and accompanying text *infra*.

important preventable environmental factor contributing to illness, disability, and death in the United States, and health damage resulting from cigarette smoking cost the nation an estimated 27 billion dollars in medical care, absenteeism, decreased work productivity, and accidents.[28] In 1970, a public opinion poll reported that 87.5% of the population agreed with the statement: "Smoking cigarettes is harmful to health."[29] Despite the wide recognition that cigarette smoking is harmful to the smoker, less is known about the danger of involuntary smoking.

Involuntary smoking, also called passive smoking or second-hand smoking, occurs when a nonsmoker breathes air that contains the tobacco smoke of a smoker.[30] The tobacco smoke in the air comes from two sources: mainstream and sidestream smoke. Mainstream smoke is the smoke that is pulled through the cigarette by the smoker. It is filtered both by the cigarette and the lungs of the smoker. Sidestream smoke is the unfiltered smoke from the lit end of a burning cigarette, which, because of the lack of filtering, is even more dangerous to the nonsmoker than the exhaled smoke from the smoker's mouth.[31]

Only recently has involuntary smoking been recognized as a health hazard. The bombshell 1964 Surgeon General's report did not discuss involuntary smoking. The 1972 report, however, mentioned the possible hazards of involuntary smoking,[32] and the 1975 and 1979 reports contain additional findings in this regard.[33] In addition, the American College of Chest Physicians, the World Health Organization, and the World Conference on Smoking and Health have issued statements warning of the dangers of involuntary smoking.[34] The latter two organizations have recommended restrictions on smoking in public places.[35] Also, involuntary smoking has been the subject of a large number of recent articles in medical journals and other scholarly publications.[36]

28. 1979 Report, *supra* note 2, at vii.

29. *Antismoking Legislation*, *supra* note 14, at 181.

30. *See* 1979 Report, *supra* note 2, at 11-15.

31. A. Brody & B. Brody, The Legal Rights of Nonsmokers 21 (1977) [hereinafter cited as Brody]; *Non-smoker*, *supra* note 15, at 144.

32. 1972 Report, note 5 *supra*.

33. *See* note 6 and accompanying text *supra*.

34. Brody, *supra* note 31, at 14; Action On Smoking & Health, History of the War Against Smoking 1964-1978 (n.d.). Action On Smoking and Health (ASH), 2000 H. Street, N.W., Washington, D.C. 20006, is a national non-profit charitable organization dedicated to reducing "the deadly toll of smoking, and to protect[ing] the rights of nonsmokers." *Id.* ASH was formed in 1967 by attorneys, physicians, and other citizens who felt there was a need for legal action against smoking.

35. Brody, *supra* note 31, at 14.

36. The 1979 Report, note 2 *supra*, lists 85 documents relating to the dangers of involuntary smoking. Humorist Art Buchwald reports "another side to the story. Smokers believe that Involuntary Smokers are just getting a free smoke from the cigarette addict." Buchwald quotes a smoker, one Morris Phillip, as

Although the full extent of the dangers of involuntary smoking is not yet known, certain conclusions have already been stated with confidence:

1. Most healthy people in involuntary smoking situations suffer minor eye and throat irritation.[37]

2. Involuntary smoking by healthy people can cause slight deterioration in psychomotor performance, especially attentiveness and cognitive function.[38]

3. Involuntary smoking does significant harm to fetuses, infants, and children.[39]

4. People with certain heart diseases may suffer exacerbations of their symptoms as a result of involuntary smoking.[40]

5. People with certain lung diseases (*e.g.*, chronic bronchitis, emphysema) have considerable excess mortality under conditions of severe air pollution, and involuntary smoking situations can produce pollutants to a degree as high or higher than those that occur during air pollution emergencies.[41] The U.S. Public Health Service reports that there are 15½ million people with such chronic lung problems in the United States.[42]

6. Many individuals appear to be allergic to tobacco smoke.[43] Estimates range from 1.5 million to at least 34 million.[44] Symptoms vary from "eye irritation, nasal symptoms, headache, cough, wheezing, sore throat, nausea, hoarseness, dizziness, upper respiratory tract distress, choking sensation, loss of memory, lightheadedness, difficulty in concentration, depressive personality changes, double vision, short blackouts, to lesions on the skin."[45]

saying, "We primary smokers are sick and tired of being bugged by secondary smokers, particularly when they start wheezing and sneezing and having a good time at our expense." Columbia (Mo.) Tribune, July 31, 1979, at 4, col. 1.

37. 1979 REPORT, *supra* note 2, at 11-25; 1975 REPORT, *supra* note 6, at 107; *Antismoking Legislation*, *supra* note 14, at 178.

38. 1979 REPORT, *supra* note 2, at 11-34.

39. BRODY, *supra* note 31, at 33; PUBLIC HEALTH SERVICE, U.S. DEPARTMENT OF HEALTH, EDUCATION AND WELFARE, THE SMOKING DIGEST 26 (1977) [hereinafter cited as SMOKING DIGEST].

40. 1979 REPORT, *supra* note 2, at 11-29; 1975 REPORT, *supra* note 6, at 107; SMOKING DIGEST, *supra* note 39, at 24. A recent experiment concluded that involuntary smoking is deleterious to the nonsmoker and significantly reduces small airways function. White & Froeb, *Small-Airways Dysfunction in Nonsmokers Chronically Exposed To Tobacco Smoke*, 302 NEW ENG. J. MED. 720 (1980).

41. 1979 REPORT, *supra* note 2, at 11-31; 1975 REPORT, *supra* note 6, at 105; SMOKING DIGEST, *supra* note 39, at 24-26.

42. Testimony of David P. Cook, Program Director of the American Lung Association of Western Missouri, before the Judiciary Committee of the Missouri House of Representatives (Jan. 16, 1979).

43. BRODY, *supra* note 31, at 33; SMOKING DIGEST, *supra* note 39, at 21. The 1979 REPORT, note 2 *supra*, states, "the existence of a true tobacco allergy has not been clearly established," but speculates that people allergic to other things may also be allergic to tobacco smoke. *Id.* at 11-31.

44. BRODY, *supra* note 31, at 33; Comment, *Where There's Smoke There's Ire: The Search for Legal Paths to Tobacco-Free Air*, 3 COLUM. J. ENVT'L L. 62, 67 (1976) [hereinafter cited as *Ire*].

45. BRODY, *supra* note 31, at 33 (footnotes omitted).

7. Involuntary smoking may contribute to the development of serious diseases in otherwise healthy individuals.[46]

In short, the danger of cigarette smoke to nonsmokers is a significant health problem. Most healthy people experience discernible, physical irritation as a result of involuntary smoking.[47] Moreover, an exposure to involuntary smoking that causes only minor consequences to a healthy person may have a much more severe effect on children, people with allergies, or people suffering from heart or lung disease.[48] The number of people seriously affected by the smoke of other people's cigarettes may be as high as 34 million.[49]

IV. SMOKING LEGISLATION

A. *Public Attitude*

The recent revelations about the dangers of involuntary smoking have prompted a great deal of legislative action during the seventies. Federal, state, and local governments and agencies are heeding the growing medical evidence and the changing attitudes of the public about smoking. As awareness of the danger of smoking has increased, the attitude of people toward smokers has altered significantly. In surveys done by the Department of Health, Education, and Welfare,[50] people were asked to respond to the statement, "It is annoying to be near a person who is smoking cigarettes." Their responses:

	1964	*1966*	*1970*
Agree	44.8%	47.4%	58.5%
Disagree	51.7%	48.6%	38.3%

A 1978 survey in St. Joseph, Missouri,[51] asked the same question. Over

46. More than 3000 components of tobacco smoke have been identified, and several have been implicated in the development of specific diseases. Upwards of 90% of cigarette smoke is composed largely of a dozen gases that are hazardous to health, and the remainder is particulate matter, of which tar and nicotine are two of the best known components. SMOKING DIGEST, *supra* note 39, at 17. Research done on laboratory animals has serious implications for human beings: a significant number of mice exposed to second-hand smoke over a two-year period developed severe bronchitis and inflammation of the bronchial tubes that connect the windpipe with the lungs; rabbits exposed to smoke from 20 cigarettes per day for two to five years developed emphysema; dogs exposed to cigarette smoke ten times per week for one year suffered a breakdown in lung tissues; rats exposed to second-hand smoke for 45 minutes a day for two to six months showed twice as many lung tumors as a control group. SECOND-HAND SMOKE—AN AMERICAN LUNG ASSOCIATION BROCHURE, *reprinted in* D. SHIMP, HOW TO PROTECT YOUR HEALTH AT WORK 115-21 (1976) [hereinafter cited as SHIMP BOOK].

47. *See* note 37 and accompanying text *supra*.

48. 1979 REPORT, *supra* note 2, at 11-29.

49. *See* note 44 and accompanying text *supra*.

50. *Antismoking Legislation*, *supra* note 14, at 181.

51. The St. Joseph Chapter of the Center for Nonsmokers' Rights conducted a 100-call random telephone survey of adults 18 years and older (Feb. 1978). Information obtained from the American Lung Association of Western Missouri, 2007 Broadway, Kansas City, Mo. 64108.

60% of the population surveyed agreed with the statement, and 40% of the smokers agreed with it.[52]

In the surveys, the people were also asked for a response to the statement: "The smoking of cigarettes should be allowed in fewer places than it is now."[53] Even in 1964, 51.2% agreed with the statement.[54] Since then, the percentage of people agreeing has steadily increased.[55] A nation-wide study conducted in 1978 for the Tobacco Institute by the Roper Organization had the following results: 62% favored separating smokers from nonsmokers at train stations, airports, and bus stations; 61% favored separation in the work place; 73% favored separation at indoor sporting events; and 75% favored separation in eating places.[56] The survey results clearly indicate that the legislator who advocates a statute restricting smoking in public has the support of a majority of Americans.

B. *State Statutes*

As of 1980, thirty-four states and the District of Columbia have legislation restricting smoking in various places in order to reduce involuntary smoking, and one state accomplishes the same result by extensive administrative regulations.[57] The statutes restricting smoking vary greatly

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52

	Smokers	*Nonsmokers*	*Combined %*
Agree	40%	75%	61%
Disagree	52.5%	21.7%	34%
Don't know	7.5%	3.3%	5%

53 See notes 50 & 51 *supra*.

54 *Nonsmoking Legislation*, *supra* note 14, at 181.

55

	HEW Survey			*1978 St. Joseph Survey*		
	1964	*1966*	*1970*	*Smokers*	*Non-smokers*	*Combined %*
Agree	51.2%	51.8%	56.8%	35%	68.3%	55%
Disagree	38.8%	36.8%	36.3%	55%	15%	31%
Don't know	–	–	–	10%	16.7%	14%

56 Wall St. J., Oct. 23, 1979, at 5, col. 2.

57 For states enacting legislation to reduce involuntary smoking, see Groups I, II, and III below. Other states have legislation restricting smoking, enacted for reasons other than protecting nonsmokers. *See* Group IV below. A few states have no legislation restricting smoking. *See* Group V below.

GROUP I: ALASKA STAT. §§ 18.35.300, .310, .320, .330, .340 (Cum. Supp. 1979); ARIZ. REV. STAT. ANN. § 36-601.01 (1974); ARK. STAT. ANN. §§ 82-3701 to -3705 (Cum. Supp. 1979); COLO. REV. STAT. §§ 25-14-101 to -105 (Cum. Supp. 1978); CONN. GEN. STAT. ANN. § 1-21b (West Cum. Supp. 1980); GA. CODE ANN. § 26-9910 (1977); HAWAII REV. STAT. §§ 321-201 to -206 (1976); IOWA CODE §§ 98A.1-.6 (Supp. 1980); KAN. STAT. ANN. § 21-4008 (Cum. Supp. 1979); MASS. GEN. LAWS ANN. ch. 270, § 21 (West Cum. Supp. 1980); MINN. STAT. ANN. §§ 144.411-.417 (West Supp. 1980); 1979 Mont. Laws ch. 368; NEB. REV. STAT. §§ 71-5701 to -5715 (Supp. 1979); NEV. REV. STAT. §§ 202.2490-2492 (1975); N.H. REV. STAT. ANN. § 155:42 (Supp. 1979); N.J. REV. STAT. § 2C:33-13 (Supp. 1979); N.Y. PUB. HEALTH LAW §§ 1399-o to -q (McKinney Supp. 1979); N.D. CENT. CODE §§ 23-12-09 to -11 (1978); OHIO REV. CODE ANN. § 379.031 (Page Supp. 1979); OKLA. STAT. ANN. tit. 21, § 1247 (West Supp. 1979); R.I. GEN. LAWS §§ 23-56-1, -2 (Cum. Supp. 1978); S.D. CODIFIED LAWS ANN. §§ 22-36-1, -2 (1979); TEX. PENAL CODE ANN. tit. 10, § 48.01 (Vernon Supp. 1979); UTAH CODE ANN. §§ 76-10-101 to -110 (Cum. Supp. 1975); 218 WAC 152 (1975) (Washington state regulations).

in scope and function. Twenty-five states have a specific and fairly comprehensive statute restricting smoking in public.[58] Generally, Clean Indoor Air legislation contains the four elements that the American Lung Association has identified as common to effective anti-smoking legislation:

> 1. Definition of terms, particularly those words which have more than one connotation (*e.g.*, "public place").
>
> 2. Requirement that plainly visible signs be posted in all areas where smoking is restricted or prohibited to alert everyone to the regulations in effect.
>
> 3. Clear delegation of authority: identification of the officials and/or agencies responsible for the publicity, posting, and enforcement of the regulations.
>
> 4. Designation of penalties for violations to provide incentives for adhering to the regulations.[59]

GROUP II: MD. ANN. CODE art. 38A, § 23 (1957) (fireworks), art. 43, § 54-I (1957) (physicians' offices, nursing homes, hospitals), art. 43, § 200 (1957) (food canning), art. 78, § 35A (Supp. 1979) (buses), art. 89, § 64 (1957) (elevators); MICH. COMP. LAWS §§ 333.21333 (1980) (homes for the aged), 333.21531 (1980) (hospitals), 333.21733 (1980) (nursing homes), 408.820 (Supp. 1980) (elevators), 289.707a (Supp. 1980) (retail food establishments), 333.12905 (1980) (restaurants), 289.129 (1967) (canneries); OR. REV. STAT. §§ 243.345, .350 (1979) (state offices), 192.710 (1979) (public meetings), 441.815 (1979) (hospitals), 479.015 (1979) (elevators).

GROUP III: CAL. HEALTH & SAFETY CODE §§ 25940, 25940.5, 25941 to 25947 (West Supp. 1980) (certain areas in publicly owned buildings); CAL. PUB. UTIL. CODE § 561 (West Supp. 1980) (public transportation) (California's Clean Indoor Air Act, ch. 10.7, was rejected at the general election held Nov. 7, 1978); DEL. CODE ANN. tit. 11, § 1326 (1979) (buses); D.C. CODE ANN. § 44-216 (Supp. 1978) (public transportation); FLA. STAT. §§ 823.12 (1976) (elevators), 255.27 (Supp. 1980) (government buildings); IDAHO CODE §§ 18-5904 to -5906 (1979) (public meetings); MISS. CODE ANN. § 97-35-1(4), (7) (1972) (buses); PA. STAT. ANN. tit. 35, § 361 (Purdon Supp. 1980) (hospitals); PA. STAT. ANN. tit. 53, § 3702 (Purdon 1972) (retail stores); PA. STAT. ANN. tit. 35, § 1225 (Purdon 1977) (theatres, public assemblies); WASH. REV. CODE ANN. § 47.56.730 (Supp. 1980) (ferries).

GROUP IV: ILL. ANN. STAT. ch. 96½, § 2105 (Smith-Hurd 1979) (mines); ILL. ANN. STAT. ch. 96½, § 2013 (Smith-Hurd 1979) (magazine); ILL. ANN. STAT. ch. 127½, § 109 (Smith-Hurd Cum. Supp. 1976) (fireworks); IND. CODE ANN. §§ 16-1-22-21, 16-6-4-23 (Burns 1973) (food processed or stored); KY. REV. STAT. ANN. § 352.170(3) (Baldwin 1977) (mines); KY. REV. STAT. ANN. § 438.050 (Baldwin Cum. Supp. 1978) (school premises); LA. REV. STAT. ANN. § 17:416(A) (West Supp. 1980) (school premises); ME. REV. STAT. ANN. tit. 25, § 2453 (1964) (mills, buses, factories, shipyards; fire prevention in mind); RSMo § 320.130 (1978) (fireworks); N.M. STAT. ANN. §§ 63-7-2, -3, 63-14-17 (1974) (mines); S.C. CODE §§ 23-35-90, -100 (1976) (fireworks); S.C. CODE § 59-67-150 (1976) (school bus); TENN. CODE ANN. § 53-3011 (1977) (fireworks); TENN. CODE ANN. §§ 59-6-103(b), 09(j), -510(a), -7-106 (1980) (mines); TENN. CODE ANN. § 59-7-108(h) (1980) (magazine); VT. STAT. ANN. tit. 20, § 2752 (1968) (building with sign posted; fire prevention measure); VA. CODE § 3-379 (1973) (food processing); VA. CODE § 45.1-59 (1974) (magazines); VA. CODE § 45.1-98 (1974 & Cum. Supp. 1979) (mines); W. VA. CODE § 21-3-8 (1978) (factories, mercantile establishments); W. VA. CODE § 16-9-7 (1979) (schools); W. VA. CODE § 22-2-57(b) (1978) (mines); W. VA. CODE § 22-2-53 (1978) (mine surface); WYO. STAT. § 30-6-107 (1977) (mines).

GROUP V: Alabama, North Carolina, and Wisconsin.

58. Group I, note 57 *supra*.

59. SMOKING DIGEST, *supra* note 39, at 85.

Three states have a group of statutes, rather than one single comprehensive statute, which limit the places where smoking may occur.[60] In effect, these statutes are probably just as comprehensive as those in most single-statute states. Seven states and the District of Columbia have statutes for protection of nonsmokers that only prohibit smoking in a particular public place.[61] These statutes typically mention only buses or elevators, although some proscribe smoking in certain public meetings, government buildings, retail stores, or hospitals. Thirteen states have statutes prohibiting smoking in certain areas, not because of the air pollution danger to nonsmokers, but because of fire hazards, food contamination, or restrictions on smoking by children at school.[62] Three states have no statutes prohibiting smoking.[63]

All twenty-five comprehensive anti-smoking statutes were enacted since 1974. The first state to pass a comprehensive law prohibiting smoking in designated public places was Arizona.[64] The most recent was Connecticut, where the Connecticut Clean Indoor Air Act went into effect October 1, 1979.[65] The comprehensive statutes vary greatly in detail, but many of them contain similar characteristics.

Several state statutes declare in a preamble that smoking is a health hazard[66] or a public nuisance.[67] A few legislatures have gone even further in stating the statutory purpose, saying that the statute is meant to protect the right of the nonsmoker to breathe clean air.[68] Such a statement of

60. Group II, note 57 *supra*.
61. Group III, note 57 *supra*.
62. Group IV, note 57 *supra*.
63. Group V, note 57 *supra*.
64. ACTION ON SMOKING & HEALTH, HISTORY OF THE WAR AGAINST SMOKING 1964-1978 (n.d.).
65. AMERICAN LUNG ASSOCIATION OF WESTERN MISSOURI, SMOKING AND HEALTH REPORT (Sept. 1979). In Missouri, the Missouri Clean Indoor Air Act passed out of the Interstate Committee with a 3-2-1 vote in January 1980. The bill, however, died on the Perfection Calendar.
66. *See* laws from Arizona, Arkansas, California, Colorado, Minnesota, Nebraska, Nevada, Oklahoma, Oregon, Rhode Island, and Washington, cited note 57 *supra*.
67. *See* laws from Alaska, Arizona, Oklahoma, Rhode Island, South Dakota (statute listed under heading Public Nuisance), and Idaho (statute listed under heading Public Nuisance), cited note 57 *supra*.
68. ARK. STAT. ANN. § 82-3701 (Cum. Supp. 1979) provides:
> Information available to the General Assembly based upon scientific research data has shown that nonsmokers often receive damage to their health from the smoking of tobacco by others. It is therefore declared to be the public policy of the state of Arkansas that the rights of nonsmokers be protected in the manner provided in this Act.

The Rhode Island "Smoking in Public Places" statute, R.I. GEN. LAWS § 23-56-1 (Cum. Supp. 1978), has a similar preamble:
> The use of tobacco for smoking purposes is being found to be increasingly dangerous, not only to the person smoking but also to the non-smoking person who is required to breathe such contaminated air. The most pervasive intrusion of the non-smoker's right to unpolluted air space is the uncontrolled smoking in public places. The legislature intends, by the enactment of this chapter, to protect the health and atmospheric environment of the non-smoker by regulating smoking in certain public places.

legislative intent and purpose seems to be a good idea. A statute restricting smoking might have been enacted for any of several reasons, including the protection of air, the protection of food, the protection of the community from fire, or the protection of the morals of minors.[69] Situations could arise where the intent of the legislature would be significant, and in such a situation it helps to have the intent clearly spelled out.

A preamble stating that the legislature recognizes the dangers of involuntary smoking might also be useful for educational and public policy reasons. Since the dangers of involuntary smoking have only become publicized during the seventies and many skeptics still exist,[70] formal recognition of the danger by a state legislature that has heard the evidence can only serve to help the public by further educating them on the issue. Moreover, use of the words "rights of the nonsmoker" emphasizes that nonsmokers *do* have the right to breathe clean air.[71]

The definition given smoking in nonsmokers' rights legislation is important. Many states use the definition: "Smoking in a place or vehicle includes the possession, in that place or vehicle, of a lighted cigarette, cigarillo, cigar, or pipe."[72] Several statutes include the additional phrase, "or any other lighted smoking equipment."[73] Under this phrasing, any newly developed tobacco product that is not necessarily a cigarette, cigarillo, cigar, or pipe would still be covered.[74]

The designation of *where* smoking is prohibited is one of the most important parts of the Clean Indoor Air legislation. A few states prohibit smoking in all indoor public places not designated as smoking areas.[75] Representative of these statutes is Montana's definition of "indoor public place" as "any indoor area, room, or vehicle used by the general public or serving as a place of work, *including but not limited to* restaurants, stores, offices, trains, buses, educational or health care facilities, auditoriums, arenas, assembly and meeting rooms."[76] This seems a much more efficient statute than one that attempts to list all of the various indoor public places where smoking is prohibited. Since involuntary smoking is dangerous to nonsmokers, it seems better public policy to start with the presumption that smoking is *not* allowed in *any* indoor public place, and then provide

69. BRODY, *supra* note 31, at 151.
70. *See* note 131 and accompanying text *infra*.
71. For the argument that the right to breathe clean air is a fundamental right protected by the Constitution, see notes 147-83 and accompanying text *infra*.
72. *E.g.*, IOWA CODE § 98A.1 (Supp. 1980).
73. *E.g.*, MINN. STAT. ANN. § 144.413 (West Supp. 1980).
74. Professor Alvan Brody drafted a model statute with a slightly different definition: "'Smoking' means carrying or possessing any lighted tobacco product, except temporarily possessing a tobacco product lighted by another for purposes of immediate extinguishment." BRODY, *supra* note 31, at 107.
75. *See* laws from Colorado, Minnesota, Montana, Nebraska, New Jersey, and Utah, cited note 57 *supra*.
76. 1979 Mont. Laws ch. 368, § 3(2) (emphasis added).

specific smoking areas, than to start with the presumption that smoking is allowed, except in certain forbidden places.[77]

In the statutes that list places where smoking is prohibited, some areas are listed more frequently than others: twenty-four states and the District of Columbia prohibit smoking in public transportation;[78] twenty-four prohibit smoking in elevators;[79] twenty-three prohibit smoking in public waiting rooms or various other parts of health care facilities;[80] twenty-one prohibit smoking in places of recreation or entertainment, like libraries, museums, theaters, lecture or concert halls, auditoriums, or swimming pools;[81] fifteen prohibit smoking in public schools;[82] twelve prohibit smoking in state-owned buildings;[83] eleven prohibit smoking in public meetings;[84] nine restrict smoking in restaurants;[85] seven prohibit smoking in supermarkets or food stores;[86] six prohibit smoking in public department stores;[87] six prohibit or restrict smoking in any place where the proprietor has posted a "No Smoking" sign;[88] and six prohibit smoking in *any* public place "including but not limited to" a list of specified places.[89]

77. "Model legislation should ban smoking everywhere nonsmokers have a legal right to be. The burden should be on the smoker to discover where smoking is permitted." BRODY, *supra* note 31, at 106.

78. *See* laws from Alaska, Arkansas, California, Colorado, Connecticut, Delaware, District of Columbia, Georgia, Iowa, Maryland, Massachusetts, Minnesota, Mississippi, Nebraska, Nevada, New Hampshire, New Jersey, New York, North Dakota, Ohio, Oklahoma, South Dakota, Texas, Utah, and Washington, cited note 57 *supra*.

79. *See* laws from Alaska, Arizona, Colorado, Connecticut, Florida, Georgia, Hawaii, Iowa, Kansas, Maryland, Massachusetts, Michigan, Minnesota, Nebraska, Nevada, New Hampshire, North Dakota, Ohio, Oklahoma, Oregon, Rhode Island, South Dakota, Texas, and Washington, cited note 57 *supra*.

80. *See* laws from Alaska, Arizona, Arkansas, Colorado, Connecticut, Iowa, Kansas, Maryland, Massachusetts, Michigan, Minnesota, Nebraska, Nevada, New Hampshire, North Dakota, Ohio, Oregon, Pennsylvania, Rhode Island, South Dakota, Texas, Utah, and Washington, cited note 57 *supra*.

81. *See* laws from Alaska, Arizona, Colorado, Hawaii, Iowa, Kansas, Massachusetts, Minnesota, Nebraska, Nevada, New Hampshire, New York, North Dakota, Ohio, Oklahoma, Pennsylvania, Rhode Island, South Dakota, Texas, Utah, and Washington, cited note 57 *supra*.

82. *See* laws from Alaska, Arizona, California, Colorado, Connecticut, Kentucky, Louisiana, Minnesota, Nebraska, North Dakota, Ohio, Rhode Island, South Dakota, Texas, and Washington, cited note 57 *supra*.

83. *See* laws from California, Colorado, Connecticut, Florida, Iowa, Minnesota, Nebraska, Nevada, North Dakota, Ohio, Oregon, and Utah, cited note 57 *supra*.

84. *See* laws from Alaska, Colorado, Connecticut, Hawaii, Idaho, Minnesota, Nebraska, Nevada, Oregon, Utah, and Washington, cited note 57 *supra*.

85. *See* laws from Colorado, Connecticut, Michigan, Minnesota, Montana, North Dakota, Ohio, Nebraska, and Utah, cited note 57 *supra*.

86. *See* laws from California, Connecticut, Massachusetts, Michigan, Minnesota, Nebraska, and Rhode Island, cited note 57 *supra*.

87. *See* laws from Colorado, Minnesota, Nebraska, Pennsylvania, Utah, and Washington, cited note 57 *supra*.

88. *See* laws from Alaska, Arizona, Georgia, New Hampshire, New Jersey, and Utah, cited note 57 *supra*.

89. *See* note 75 *supra*.

Most of the specifically named no-smoking areas share the characteristic of being a public place where many people are gathered closely together. Buses, elevators, waiting rooms, theaters, classrooms, and public meeting halls are all viewed as places where if one person smokes, everyone smokes, whether they hold the cigarette or not. These are the most obvious places where smoking should be prohibited.

Another obvious place where smoking should be prohibited is the health care facility. Because people who suffer heart and lung disease have been proven to be the most susceptible to immediate injury from exposure to cigarette smoke,[90] smoking should clearly be prohibited in the places where the sick have gone to seek medical assistance.

An often overlooked place where smoking should be prohibited or restricted is the workplace. Only at the workplace is the nonsmoker required to spend eight hours per day at his assigned spot. If the spot is next to a smoker, the nonsmoker will probably experience some discomfort or even illness.[91] Many companies have voluntarily prohibited smoking in the workplace.[92] Several offer bonuses to employees who stop smoking.[93] Other companies, however, may prefer to irritate the nonsmokers than the smokers.[94] The statutes in Colorado,[95] Minnesota,[96] Montana,[97] Nebraska,[98] Oregon,[99] and Utah[100] contain sections specifically dealing with smoking in the workplace.

The Minnesota, Montana, Nebraska, and Utah statutes specify enclosed indoor areas "serving as a place of work" as areas where smoking is prohibited. The Minnesota statute is representative. It states that "the department of labor and industry shall, in consultation with the state board of health, establish rules to restrict or prohibit smoking in those places of work where the close proximation of workers or the inadequacy of ventilation causes smoke pollution detrimental to the health and comfort of non-

90. *See* notes 40-45 and accompanying text *supra*.

91. A recent study indicates that 70% of nonsmokers who are not allergic to tobacco smoke suffer eye irritation when exposed to tobacco smoke. Of nonsmokers with allergies, 73% suffer eye irritation. The figures for nasal irritation are 29% and 67%, respectively. *See Antismoking Legislation*, *supra* note 14, at 178.

92. J.C. Penney, N.L.T. Corp., and Continental Illinois Bank separate smokers from nonsmokers. SHIMP BOOK, *supra* note 46, at 3. Thomas Edison refused to hire smokers. S. WAGNER, *supra* note 1, at 42.

93. Cybertek Computer Products, Inc., of Los Angeles, Intermatic Inc., of Spring Grove, Ill., and Speed Call Corp., of Hayward, Cal., all pay their employees not to smoke at work. ACTION ON SMOKING AND HEALTH, ASH NEWSLETTER (Jan.-Feb. 1980).

94. Professor Alfred W. Blumrosen has suggested that a company might take this approach out of inertia. SHIMP BOOK, *supra* note 46, at 42.

95. COLO. REV. STAT. § 25-14-102 (Cum. Supp. 1978).

96. MINN. STAT. ANN. § 144.413 (West Supp. 1980).

97. 1979 Mont. Laws ch. 368, § 5(2).

98. NEB. REV. STAT. § 71-5701 (Supp. 1979).

99. OR. REV. STAT. § 243.350 (1979). The Oregon statute restricting smoking in the workplace only applies to places of employment operated by the state of Oregon.

100. UTAH CODE ANN. § 76-10-101 (Cum. Supp. 1978).

smoking employees."[101] Although involuntary smoking bothers some nonsmokers less than others, it is important for courts interpreting "comfort" to be familiar with the evidence that involuntary smoking causes at least physical discomfort to the *majority* of its victims.[102]

One key feature of the legislation restricting smoking in the workplace is an exception for enclosed offices occupied exclusively by smokers.[103] Under this exception, a private, enclosed office occupied exclusively by smokers, even if visited by nonsmokers, is not considered a public place for purposes of the statute. Without this provision, a law prohibiting smoking in the workplace could have the unintended effect of prohibiting smoking in the confines of one's private office.

Some statutes restricting smoking include a provision to the effect that existing physical barriers and ventilation systems shall be used to minimize the toxic effect of smoking in adjacent nonsmoking areas.[104] The wisdom of this provision is debatable. Existing partitions and ventilation systems may be ineffective in preventing potentially harmful amounts of smoke[105] from drifting into the nonsmokers' areas. On the other hand, achieving absolute separation by requiring solid walls and new ventilation systems could be inordinately costly for many businesses and organizations. The legislatures evidently have balanced these considerations and have decided the large cost outweighs the questionable harm. Steps should be taken, however, to ensure that new buildings are designed to protect nonsmokers from the outset. Also, government and private bodies large enough to afford the cost should be encouraged to make structural changes necessary to provide the maximum protection immediately.

Many of the Clean Air statutes require "No Smoking" signs in certain situations.[106] These requirements serve several functions: proprietors who might not do so voluntarily are forced to put up the signs; many smokers notice the signs and presumably obey them; and the people who smoke in spite of the signs have at least been warned that smoking is prohibited in the particular area.

Another important provision of the Clean Air legislation is the section delegating authority for enforcement and implementation. In Minnesota, for example, the State Commissioner of Health is charged with the responsibility of adopting regulations to implement the statute.[107] The commissioner, a local board of health, and any affected party are specifically given the authority to institute injunctive action.[108] Other statutes go into less

101. MINN. STAT. ANN. § 144.414 (West Supp. 1980).
102. *See* notes 37-49 and accompanying text *supra*.
103. *E.g.*, MINN. STAT. ANN. § 144.413 (West Supp. 1980).
104. *See* NEB. REV. STAT. § 71-5708 (Supp. 1979).
105. The smoke from one cigarette smoked in four minutes in a room the size of a typical office can produce 36 times the amount of tar particulates considered safe by federal standards. *Ire*, *supra* note 44, at 66.
106. *E.g.*, MINN. STAT. ANN. § 144.416 (West Supp. 1980).
107. MINN. STAT. ANN. § 144.417 (West Supp. 1980).
108. *Id.*

detail, simply saying the provisions of the act shall be supervised and enforced by local health boards.[109] Many state legislatures have neglected to include any such provision.

The penalty provisions in the various nonsmokers' rights statutes differ significantly, though none are as severe as Tsar Michael's penalties of torture or exile for persons violating his rule against the sale or use of tobacco.[110] The stiffest penalties in the United States are in Minnesota, where the offending smoker is subject to a fine of up to five hundred dollars, or a jail sentence of up to ninety days.[111] The least severe penalties are in Colorado and Massachusetts, which have no penalty provisions at all.[112] Typical penalties in other states are fines of "not more than two hundred dollars,"[113] "ten to one hundred dollars,"[114] or as low as five dollars.[115] Since the purpose of the nonsmoking statutes is to protect the health of nonsmokers, the stiffer penalties seem justified; the penalty ought to be at least high enough to deter violations.

Some statutes penalize not only the smoker, but the proprietor, or person in control of the area, for breach of his duty to protect nonsmokers.[116] In order to justify punishment at this level, the statutes first create a duty. For example, the Minnesota statute states that the proprietor or other person in charge of a public place shall make reasonable efforts to prevent smoking by: (1) posting "No Smoking" signs; (2) arranging separate smoking and no-smoking areas; (3) requesting smokers violating the law to cease; or (4) by other appropriate means.[117] Several states inflict a higher penalty on proprietors who have failed to stop the smoker than on the smoker himself.[118] A proprietor who faces a potential $500 fine for his failure to act has a strong incentive to take affirmative action to stop smoking in no smoking areas.

Another statutory remedy available to the nonsmoker in some states is the injunction. Minnesota law specifically allows an injunction to be sought by the State Commissioner of Health, a local board of health, or any affected party.[119] Even in states where injunctive relief is not expressly allowed by statute, it might be available under common law theories.[120]

109. 1979 Mont. Laws ch. 368, § 8.
110. S. WAGNER, *supra* note 1, at 12.
111. MINN STAT. ANN. § 609.03(3) (West Supp. 1980). Utah also has a stiff penalty, providing for a fine of up to $299 and a jail sentence not exceeding 90 days. UTAH CODE ANN. §§ 76-3-204, -205, -301, -10-110 (1978).
112. COLO. REV. STAT. §§ 25-14-101 to -105 (Cum. Supp. 1978); MASS. GEN. LAWS ANN. ch. 270, § 21 (West Cum. Supp. 1980).
113. *E.g.*, N.J. REV. STAT. § 2C:33-15 (Supp. 1979).
114. *E.g.*, ARK. STAT. ANN. § 82-3703 (Cum. Supp. 1979).
115. *E.g.*, IOWA CODE § 98A.6 (Supp. 1980) ($5 for the first violation, $10 to $100 for each subsequent violation).
116. *See* laws from Alaska, Connecticut, Iowa, Nevada, New Hampshire, North Dakota, Ohio, Oklahoma, and Utah, cited note 57 *supra*.
117. MINN. STAT. ANN. § 144.416 (West Supp. 1980).
118. *See* laws from Alaska, North Dakota, and Utah, cited note 57 *supra*.
119. MINN. STAT. ANN. § 144.417 (West Supp. 1980).
120. *See* notes 184-200 and accompanying text *infra*.

In addition to the many state laws concerning involuntary smoking, several local ordinances are on the books. Chicago has a special "smokers' court," the Public Safety Court, set up in 1975 to prosecute violators of the ban on smoking in public places.[121] New York City and Cincinnati have ordinances prohibiting smoking;[122] Kansas City has ordinances prohibiting smoking on buses and in stores;[123] and St. Louis has ordinances prohibiting smoking on buses, on street cars, in the multi-sports arena, and in motion picture projection booths.[124]

Although many state and local measures exist, the enforcement of these laws has had uneven success. In Florida in 1976, a man was convicted and fined $250 for smoking in an elevator.[125] A nonsmoker with a chronic bronchial asthma condition had been in the elevator with the smoker and, pointing to the "No Smoking by Law" sign, had asked that he stop smoking. The man declared that he had enough money to pay a fine and he blew smoke into the face of the nonsmoker. The nonsmoker filed a complaint, and the smoker became the first person ever to be convicted and fined for smoking in an elevator.[126] In Minnesota in 1976, George McKeever, a 70-year-old man, was convicted under the Minnesota Clean Indoor Air Act and fined $10.[127] The judge, who did not approve of the Minnesota law, suspended the minimum fine and dismissed the old man with the gentle rebuke, "Go and sin no more."[128] The result of the McKeever case may have been affected by factual questions of whether the old man's pipe had been lit, and whether the nonsmoker had banged him in the leg with her shopping cart. A survey conducted by the *Minnesota Tribune* in June 1978 indicated that 75% of Minnesota nonsmokers and 70% of Minnesota smokers favored strict enforcement of the Minnesota law.[129] New York City has evidently been very effective in handling violations of its nonsmoking ordinance. The statistics as of March 1975 revealed an 88% conviction rate.[130]

One recent commentator has criticized laws that make smoking in indoor public places a crime as being the enforcement of moral condemnation through the criminal law.[131] Dismissing the evidence that involuntary smoking is harmful to nonsmokers, the commentator equates nonsmokers' rights legislation with laws concerning littering, dogs misbehaving on public grass, and people playing their loud radios on the public bus.[132] The major fallacy in this analysis is the non-recognition of the fact that involuntary smoking *is* dangerous.[133] Unlike laws regulating morality, Clean Air statutes are health measures, just as are laws penalizing drunk driving. A statute prohibiting the consumption of alcoholic beverages would clearly constitute government enforcement of moral judgments. A statute prohibiting *driving* while intoxicated, however, is obviously designed to protect the health and safety of other members of society. In the same way, modern Clean Air legislation is not enacted to prohibit smokers from smoking, as the old statutes were,[134] but to prohibit them from smoking *in public places where their smoke might harm other members of the public.*[135]

Another criticism of Clean Air legislation is the argument that if nonsmokers are the majority of the population, and if they are bothered or injured by cigarette smoke, they will stay away from public places where smoking is allowed, and the ensuing economic pressure will force proprietors to provide nonsmoking areas, without undesirable arm-twisting by the government. The answer to this argument is that this problem is a health issue, not an economic issue. Laws regarding the safety of food and the safety of transportation exist. Laws regarding the safety of the air seem equally important. In addition, common sense dictates that the nonsmoker should not be forced to stay away from public places out of fear for his health; rather, the smoker should be restricted to practicing his habit in places where innocent bystanders will not be injured.

C. *Federal Actions*

Nonsmokers currently receive some protection from federal legislation and regulations. The legislative protection has, to this point, been indirect. Since 1965, the federal government has required each package of cigarettes to bear a label warning of the dangers of cigarette smoking.[136] Since 1971, cigarette commercials have been banned from television and radio.[137] These measures may have helped the nonsmoker by reducing the percentage of the population that smokes, thereby reducing the exposure of the nonsmoker

121. BRODY, *supra* note 31, at 105 (803 arrest citations were issued in 1975 for violations); SMOKING DIGEST, *supra* note 39, at 84; 7 STUDENT LAW. 15, 56 (Mar. 1979).
122. SMOKING DIGEST, *supra* note 39, at 84.
123. KANSAS CITY, MO., CODE OF GENERAL ORDINANCES §§ 26.43, .44 (1967).
124. ST. LOUIS, MO., REVISED CODE §§ 716.060(16), 792.010, 811.010 (1960).
125. GOOD HOUSEKEEPING, Apr. 1979, at 118.
126. *Id.* at 120.
127. 7 STUDENT LAW. 15, 58 (Mar. 1979).
128. *Id.* Prosecutions under the Minnesota Clean Indoor Air Act reportedly have decreased since the McKeever case. *Id.*
129. AMERICAN LUNG ASSOCIATION OF WESTERN MISSOURI, SMOKING AND HEALTH REPORT (Apr.-May 1979).
130. BRODY, *supra* note 31, at 105.
131. 7 STUDENT LAW. 15, 56-58 (Mar. 1979).
132. *Id.* at 16.
133. The author reports that *only* 34 million people are allergic to tobacco smoke, evidently considering that to be an insignificant number. *Id.* at 17.
134. *See* notes 14-16 and accompanying text *supra*.
135. *See* BRODY, *supra* note 31, at 112; *Non-smoker*, *supra* note 15, at 164. In a recent case, the Virginia Supreme Court said that ordinances restricting smoking in public places are "clearly within the police power of the legislature." Alford v. City of Newport News, 260 S.E.2d 241, 245 (Va. 1979).
136. 15 U.S.C. § 1333 (1976).
137. 15 U.S.C. § 1335 (1976).

to tobacco smoke. Federal legislation that would directly protect nonsmokers, however, has been suggested,[138] but not passed.

Several federal regulations offer direct protection to nonsmokers. The Department of Defense (D.O.D.) has a comprehensive regulation prohibiting smoking in auditoriums, elevators, shuttle vehicles, medical care facilities, conference and class rooms, and work areas.[139] The regulation also requires nonsmoking areas to be designated in D.O.D. eating facilities. The General Services Administration has a similar regulation, which became effective in April 1979.[140] The Interstate Commerce Commission has a regulation limiting the smoking section of a bus, when such a section is provided at all, to the back thirty percent of the seats.[141] A Civil Aeronautics Board regulation requires passenger aircraft to provide a "No Smoking" area large enough to include all passengers who want it.[142] Smoking is also prohibited in trains, except in designated areas.[143]

Expansion of federal legislation and regulation would have both advantages and disadvantages. One advantage of a federal "Clean Indoor Air Act" would be more nationwide uniformity. One of the problems with enforcement of no-smoking legislation has been "the patchwork quality of such legislation."[144] To illustrate, a resident of Missouri, who has never been subjected to a no-smoking law, might assume that smoking is allowed in a bus in California. Even a "No Smoking" sign might not adequately inform him of the California law. Nevertheless, the health hazard of smoking seems to be the type of public problem that is best controlled by the state, rather than the federal government. Although the federal government arguably has the power to enact a comprehensive non-

138. Massachusetts Representative Robert Drinan has introduced nonsmokers' rights legislation several times. BRODY, *supra* note 31, at 118. The bill he introduced in 1975 would have restricted smoking in all federal facilities and public facilities associated with common carriers engaged in interstate commerce, and would have guaranteed, as much as economically feasible, smoke-free work areas for federal employees. *Id.*

139. 32 C.F.R. § 203 (1979).

140. AMERICAN LUNG ASSOCIATION OF WESTERN MISSOURI, SMOKING AND HEALTH REPORT (Sept. 1979).

141. 49 C.F.R. § 1061 (1979).

142. 14 C.F.R. § 252 (1979). This regulation was enacted in response to complaints from nonsmokers and a government study showing that 60% of nonsmoking passengers and 38% of all passengers were bothered by smoke. SMOKING DIGEST, *supra* note 39, at 81. *See also* 38 FED. REG. 12,210 (1973).

143. 49 C.F.R. § 1121.21 (1979). In 1972, a nonsmoker was bothered by the tobacco smoke in the first-class section of an Amtrak train. When he complained to the conductor he was told that smoking was permitted in the first-class car, and if he did not like it he could move to a second-class car. He later complained to Amtrak officials and as a result of his influence, cigar and pipe smoking were banned in the first-class club car of the train. Not all nonsmokers, though, have the clout of Chief Justice Warren E. Burger. *Tobacco Pollution and the Nonsmoker's Rights*, 4 ENVT'L L. 451 (Spring 1974).

144. BRODY, *supra* note 31, at 106.

smokers' rights statute,[145] uniformity can also be achieved by adoption of uniform legislation by the states.[146]

V. CONSTITUTIONAL THEORIES

Commentators on the issue of nonsmokers' rights are fond of quoting the observation of George Bernard Shaw that "smokers and non-smokers cannot be equally free in the same railway carriage."[147] The pithy quote captures the essence of the dilemma: should the smoker be permitted to smoke, or should the nonsmoker's right to breathe clean air be protected? Although many jurisdictions have resolved the problem through legislation, in other jurisdictions the nonsmoker who seeks relief[148] must try alternative routes. One of these routes is constitutional law.

Three parts of the Constitution have been advocated as support for the right of the nonsmoker to breathe clean air: (1) the ninth amendment; (2) the fifth and fourteenth amendments; and (3) the first amendment. At this writing, no court has squarely accepted any of these arguments.[149]

A good argument can be made that the ninth amendment protects nonsmokers from cigarette smoke in public places. The ninth amendment reads: "The enumeration in the Constitution, of certain rights, shall not be construed to deny or disparage others retained by the people."[150] As Justice Story wrote, the "Bill of Rights presumes the existence of a substantial body of rights not specifically enumerated but easily perceived in the broad concept of liberty and so numerous and so obvious as to preclude listing them."[151] Therefore, as Professor Lawrence Tribe explains, the ninth amendment "at least states a rule of construction pointing away from the reverse incorporation view that only the interests secured by the Bill of Rights are encompassed within the fourteenth amendment, and at most provides a positive source of law for fundamental but unmentioned

145. A Federal Clean Indoor Air Act probably could be supported by the Commerce clause. BRODY, *supra* note 31, at 119.

146. The Minnesota Clean Indoor Air Act is often used as a model by other states. SMOKING DIGEST, *supra* note 39, at 86.

147. *Antismoking Legislation*, *supra* note 14, at 167; *Non-Smoker*, *supra* note 15, at 165; 7 STUDENT LAW. 15, 16 (Mar. 1979).

148. The nonsmoker considering legal action might be able to obtain organized assistance. Action On Smoking and Health (ASH), 2000 H Street, N.W., Washington, D.C. 20006, is a national nonprofit organization dedicated to protecting the rights of nonsmokers. The American Lung Association, 1740 Broadway, New York, N.Y. 10019, might be of some help. Nonsmokers in the Midwest should contact the American Lung Association of Western Missouri, 2007 Broadway, Kansas City, Mo. 64108.

149. The dictum of Environmental Defense Fund v. Hoerner Waldorf Corp., 1 E.R. 1640, 3 E.L.R. 20,791 (D. Mont. 1970), supports a constitutional right to clean air. *See* note 160 and accompanying text *infra*.

150. U.S. CONST. amend. IX.

151. 3 J. STORY, COMMENTARIES ON THE CONSTITUTION OF THE UNITED STATES 715-16 (1833), *quoted in* L. TRIBE, AMERICAN CONSTITUTIONAL LAW 570 (1978).

rights."[152] Several authorities have argued persuasively that a basic unenumerated constitutional right is the right to breathe clean air.[153] One writer has said that "like food and water, the biological necessity of clean air to support life dictates that the right to a healthful environment be recognized, or all other rights are meaningless phrases."[154]

Courts that have considered the issue of a fundamental right to a clean environment under the ninth amendment have consistently refused to recognize such a right.[155] The issue was directly addressed in 1978 in *Gasper v. Louisana Stadium & Exposition District.* [156] There, plaintiffs brought a class action under 42 U.S.C. § 1983 to enjoin officials from allowing tobacco smoking during events in the enclosed Superdome. The district court disagreed with the argument in no uncertain terms: "To hold that the First, Fifth, Ninth, or Fourteenth Amendments recognize as fundamental the right to be free from cigarette smoke would be to mock the lofty purposes of such amendments and broaden their penumbral protections to unheard-of boundaries."[157] The judge felt that the right to breathe smoke-free air was not on a constitutional par with the right to privacy in marriage, and he believed the legislative and executive branches should make the "final decisions in matters of this type."[158]

Closely related to the ninth amendment claim are the claims made under the fifth and fourteenth amendment due process clauses. Under these theories, forcing a nonsmoker to choose between staying in a smoke-filled room where he has the right to be or leaving the area deprives him

152. L. TRIBE, *supra* note 151, at 570. Some of the fundamental but unenumerated rights that have been recognized are: the right to use birth control, Griswold v. Connecticut, 381 U.S. 479 (1965); the right to travel abroad, Aptheker v. Secretary of State, 378 U.S. 500 (1964); the right to be free of certain bodily intrusions, Rochin v. California, 342 U.S. 165 (1952); the right to procreate, Skinner v. Oklahoma, 316 U.S. 535 (1942); the right to send one's child to a private school, Pierce v. Society of Sisters, 268 U.S. 510 (1925); and the right to teach one's child a foreign language, Meyer v. Nebraska, 262 U.S. 390 (1923).

153. Environmental Defense Fund v. Hoerner Waldorf Corp., 1 E.R. 1640, 3 E.L.R. 20,794 (D. Mont. 1970); BRODY, *supra* note 31, at 87-88; *Ire, supra* note 44, at 72; *Non-Smoker, supra* note 15, at 143, 165; Comment, *Toward Recognition of Nonsmokers' Rights in Illinois*, 5 LOY. CHI. L.J. 610, 614 (1974).

154. *Non-Smoker, supra* note 15, at 143.

155. Ely v. Velde, 451 F.2d 1130 (4th Cir. 1971); Gasper v. Louisiana Stadium & Exposition Dist., 577 F.2d 897 (5th Cir. 1978), *cert. denied*, 439 U.S. 1073 (1979); Federal Employees for Non-smokers' Rights v. United States, 598 F.2d 310 (D.C. Cir.), *cert. denied*, 100 S. Ct. 265 (1979); *In re* "Agent Orange" Prod. Liab. Litigation, 475 F. Supp. 928 (E.D.N.Y. 1979); Pinkney v. Ohio Environmental Protection Agency, 375 F. Supp. 305 (N.D. Ohio 1974); Tanner v. Armco Steel Corp., 340 F. Supp. 532 (S.D. Tex. 1972); Environmental Defense Fund v. Corps of Eng'rs, 325 F. Supp. 728 (E.D. Ark. 1971); GASP v. Mecklenburg County, 42 N.C. App. 228, 256 S.E.2d 477 (1979). *But see* the dictum in Environmental Defense Fund v. Hoerner Waldorf Corp., 1 E.R. 1640, 1641, 3 E.L.R. 20,794, 20,799 (D. Mont. 1970).

156. 577 F.2d 897 (1978), *aff'g* 418 F. Supp. 716 (1976), *cert. denied*, 439 U.S. 1073 (1979).

157. 418 F. Supp. at 721.

158. *Id.* at 722.

of life and liberty under the due process clause.[159] Advocates of this argument believe the right to life involves a right to health. The dictum in one environment case declared, "[T]he right to life and liberty and property are constitutionally protected. Indeed the Fifth and Fourteenth Amendments provide that these rights may not be denied without due process of law, and surely a person's health is what, in a most significant degree, sustains life."[160] Since the due process clause has been read with the ninth amendment to protect many unenumerated rights,[161] including the right to have an abortion,[162] it seems reasonable that the right to clean air be considered a fundamental right worthy of due process protection.

The *Louisiana Stadium* court rejected the due process claims, distinguishing the situation in the Superdome from that in *Pollak v. Public Utilities Commission*,[163] cited by the plaintiff. In *Pollak*, a bus company enjoyed a virtual monopoly of the mass transit in the District of Columbia, as a result of congressional authorization. The company contracted with a radio station to install speakers in the buses and to play only that station's programming. Plaintiffs were passengers who were forced to ride the bus by the lack of alternative transportation. They claimed the forced listening deprived them of liberty without due process of law. The District of Columbia Circuit Court of Appeals found that the arrangement violated the fifth amendment.[164] The primary distinction between *Pollak* and *Louisiana Stadium* is that the Superdome plaintiffs were not compelled to use the facility, as were the plaintiffs in *Pollak*, who had no alternative transportation.[165] This argument has been criticized, though, on the ground that to live a "full, normal, and healthy" life, one will inevitably find it necessary to be in public places.[166]

Another recent case, *Federal Employees for Non-Smokers' Rights v. United States*,[167] followed *Louisiana Stadium* and denied nonsmokers a cause of action under the due process clause. In *Federal Employees*, plaintiffs were nonsmokers employed by the federal government, who sought an injunction restricting smoking to designated areas of federal buildings. The

159. Gasper v. Louisiana Stadium & Exposition Dist., 577 F.2d 897 (5th Cir. 1978), *aff'g* 418 F. Supp. 716 (1976), *cert. denied*, 439 U.S. 1073 (1979); Federal Employees for Non-Smokers' Rights v. United States, 598 F.2d 310 (D.C. Cir.), *cert. denied*, 100 S. Ct. 265 (1979); BRODY, *supra* note 31, at 88-90; *Non-Smoker, supra* note 15, at 143, 165-70.

160. Environmental Defense Fund v. Hoerner Waldorf Corp., 1 E.R. 1640, 1641, 3 E.L.R. 20,794, 20,794 (D. Mont. 1970).

161. *See* note 152 and accompanying text *supra*.

162. Roe v. Wade, 410 U.S. 113 (1973).

163. 191 F.2d 450 (D.C. Cir. 1951), *rev'd*, 343 U.S. 451 (1952).

164. The Supreme Court held that there had not been a violation of due process, and reversed the court of appeals. 343 U.S. 451, 465 (1952). The plaintiff in *Louisiana Stadium*, however, argued that the *Pollak* Court had reversed on grounds other than the due process issue. 418 F. Supp. 716, 719 (1976).

165. 418 F. Supp. at 720; BRODY, *supra* note 31, at 87.

166. *Ire, supra* note 44, at 80.

167. 598 F.2d 310 (D.C. Cir.), *cert. denied*, 100 S. Ct. 265 (1979).

court denied the plaintiffs' causes of action under the Constitution and the Occupational Safety and Health Act of 1970, 29 U.S.C. § 668(a), but refused to dismiss the count brought under the common law duty of the employer to make the workplace safe.[168]

The first amendment argument was made in both *Federal Employees* and *Louisiana Stadium*. The first amendment has been interpreted to protect the right to receive information and ideas freely.[169] The ability of the nonsmoker to receive information is arguably impaired when smoking is allowed in government buildings where ideas and information are transmitted (*e.g.*, schools, auditoriums, museums, libraries).[170] The *Louisiana Stadium* plaintiffs complained that their right to exposure to events at the Superdome fit under this analysis.[171] The *Federal Employees* plaintiffs were an even better example since their right to exposure involved the workplace situation, rather than a place of entertainment.[172] In both cases the Court rejected the first amendment argument.

One commentator has suggested that nonsmokers might have a constitutional claim under the equal protection clause of the fourteenth amendment. He argues that when the state promotes legislation allowing smoking in public buildings, people sensitive to tobacco smoke are denied the equal protection of the law. In sanctioning smoking in public buildings, he contends, the state is denying to the sensitive person what it warrants to all other persons—the right of occupancy without harm to one's well-being.[173] This argument is unlikely to survive the traditional equal protection analysis. In equal protection, the rational basis test is usually used to determine the legitimacy of government actions. Only if a fundamental right or a suspect class is involved will the strict scrutiny/compelling state interest test be used.[174] Nonsmokers could hardly be called a suspect class,[175] and most courts have not considered the right to clean air as fundamental.[176] Thus, the rational basis test would be applied and the government action would probably be upheld. The equal protection clause does not seem a likely source of relief for nonsmokers.

A threshold problem with the equal protection argument is common to all of the constitutional claims by nonsmokers—the necessary element of state action. In the vast majority of cases, the problem is state *inaction*, rather than action. Only two states, Arkansas and Pennsylvania, have

168. 446 F. Supp. 181, 182, *aff'd*, 598 F.2d 310 (D.C. Cir.), *cert. denied*, 100 S. Ct. 265 (1979).
169. Stanley v. Georgia, 394 U.S. 557, 564 (1969); Lamont v. Postmaster Gen., 381 U.S. 301, 307-08 (1965); BRODY, *supra* note 31, at 86-87.
170. BRODY, *supra* note 31, at 86-87.
171. 418 F. Supp. at 717-18.
172. 446 F. Supp. at 183-85.
173. *Non-Smoker*, *supra* note 15, at 166.
174. *See generally* J. NOWAK, R. ROTUNDA & J. YOUNG, HANDBOOK ON CONSTITUTIONAL LAW 524 (1978).
175. *Id.* at 525.
176. *See* note 155 and accompanying text *supra*.

statutes specifically *allowing* smoking in public places.[177] In fact, the Pennsylvania statute goes so far as to prohibit city councils from passing ordinances that would "prohibit smoking in any restaurant room, rest room, beauty parlor, executive office or any room designated for smoking in such store."[178] In states other than Pennsylvania and Arkansas, however, the state has taken no action allowing smoking. Under present state action theory, it appears unlikely that state inaction would satisfy the state action requirement.[179] Since most states have enacted some type of non-smoking statute, however, state action might be found in passage of an inadequate statute.[180] This argument also seems weak.

Realistically, the chances of succeeding under a constitutional theory seem small for the nonsmoker at this stage of the legal conflict. The United States Supreme Court denied certiorari for the *Louisiana Stadium* case in January 1979,[181] and for the *Federal Employees* case in October 1979.[182] In light of the present Court's narrow interpretation of the concept of "Constitutional Rights" in other cases,[183] it seems unlikely this Court would resolve these constitutional theories in favor of the nonsmoker.

VI. TORT THEORIES

A. *Common Law Torts*

When legislation has not provided nonsmokers an adequate remedy at law, the common law has been found to provide protection. In what is probably the single most significant legal stride in the nonsmokers' rights movement, a New Jersey court ruled in *Shimp v. New Jersey Bell Telephone Co.*[184] that the common law duty of the employer to provide a safe workplace for employees mandates that the employer protect nonsmoking employees from the hazard of second-hand cigarette smoke.

In *Shimp*, a case of first impression, plaintiff had been employed in the offices of New Jersey Bell Telephone Company for several years. In the early seventies she began suffering a variety of severe symptoms as a result of an allergy to cigarette smoke.[185] Her allergic reaction could be

177. ARK. STAT. ANN. § 82-3702 (Cum. Supp. 1979); PA. STAT. ANN. tit. 53, §3702 (Purdon 1972).
178. PA. STAT. ANN. tit. 53, § 3702 (Purdon 1972).
179. *See Ire*, *supra* note 44, at 75.
180. *Id.*
181. 439 U.S. 1073 (1979).
182. 100 S. Ct. 265 (1979).
183. *E.g.*, Paul v. Davis, 424 U.S. 693 (1976).
184. 145 N.J. Super. 516, 368 A.2d 408 (App. Div. 1976), *noted in* Note, *Torts—Nonsmokers' Rights—Duty of Employer to Furnish Safe Working Environment Will Support Injunction Against Smoking in the Work Area*, 9 TEX. TECH. L. REV. 353 (1977); Note, *Torts—Occupational Safety and Health—Employee's Common Law Right to a Safe Workplace Compels Employer to Eliminate Unsafe Conditions*, 30 VAND. L. REV. 1071 (1977).
185. Her symptoms included skin eruptions, SHIMP BOOK, *supra* note 46, at 60, as well as severe throat irritation, nasal irritation sometimes taking the form of nosebleeds, irritation to the eyes resulting in corneal abrasion and corneal erosion, headaches, nausea, and vomiting. 145 N.J. Super. at 521, 368 A.2d at 410.

triggered by the presence of as little as one nearby smoker.[186] In the office to which she was transferred in 1975, seven of thirteen employees smoked heavily.[187] Shimp's utilization of company grievance mechanisms resulted only in the installation of an ineffective exhaust fan.[188] Shimp was offered the opportunity to move to a different location, but the move would have entailed a demotion and a decrease in pay.[189] After seeking relief through several governmental agencies, she brought suit in equity for injunctive relief.

In a landmark opinion, Superior Court Judge Phillip A. Gruccio carefully analyzed the relationship of the common law to the nonsmoker in the workplace. He stated that an employee has a right to work in a safe environment and an employer has a concomitant, affirmative duty to provide a safe work area.[190] These are widely recognized common law concepts.[191] The court noted that the Occupational Safety and Health Act did not preempt the field of occupational safety since it specifically recognized the concurrent power of a state to affect the employee-employer relationship through common law judicial and legislative action.[192] The judge recognized that cigarette smoke was toxic and dangerous to the health of this plaintiff and that of smokers and nonsmokers generally.[193] Judge Gruccio ruled that the plaintiff had not assumed the risk of harm since cigarette smoke is not a natural by-product that is a *necessary result* of the operation of the telephone business.[194] The judge noted that New Jersey Workmen's Compensation law might be a bar to monetary damages, but did not prohibit a suit for injunctive relief.[195] After considering the issues and the evidence, the court granted the injunction, and ordered New Jersey Bell to provide Shimp with safe working conditions "by restricting the smoking of employees to the nonwork area presently used as a lunch room" and prohibiting smoking "in the offices or adjacent customer service area."[196]

Although *Shimp* is a New Jersey case, it offers strong precedent for nonsmoking workers in other jurisdictions. This would be especially true in Missouri since a Missouri judge will probably find no local case directly on point. Of particular precedential value in *Shimp* are the strong statements of legal recognition of the dangers of cigarette smoke.[197] Although a

186. 145 N.J. Super. at 521, 368 A.2d at 410.
187. SHIMP BOOK, *supra* note 46, at 61.
188. 145 N.J. Super. at 521, 368 A.2d at 410.
189. SHIMP BOOK, *supra* note 46, at 61-62.
190. 145 N.J. Super. at 521, 368 A.2d at 410.
191. W. PROSSER, THE LAW OF TORTS 526 (4th ed. 1971).
192. 145 N.J. Super. at 522, 368 A.2d at 410-11.
193. *Id.* at 526, 368 A.2d at 413.
194. *Id.* at 523, 368 A.2d at 411.
195. *Id.* at 524, 368 A.2d at 412.
196. *Id.* at 531, 368 A.2d at 416.
197. *Id.* at 526-31, 368 A.2d at 413-14. Legislative declarations in state statutes and federal regulations are also valuable. *See* notes 66-71 and accompanying text *supra*.

given jurisdiction might never have recognized tobacco smoke in the air as an unsafe work environment in the past, the strong language of *Shimp* and the ever-increasing medical evidence of the danger of involuntary smoking may be enough to persuade a court of the real danger involved. Although it might be argued that *Shimp* only supports plaintiffs with allergic reactions to tobacco smoke, the New Jersey court recognized the danger of tobacco smoke to nonsmokers in general,[198] as well as to those with allergies. The only real problem for the plaintiff bringing a suit like *Shimp* is that the subject is still new and controversial; a judge hesitant to apply old law to a new fact situation, even when warranted by the evidence, might be reluctant to follow *Shimp*.[199]

Shimp involved only the employer's common law duty of providing a safe workplace, but different theories of common law duty might be found to protect nonsmokers from cigarette smoke in other places. In states where the legislature has not already dealt with the matter, the common law might protect people from cigarette smoke in common carriers, theaters, lobbies, bowling alleys, and other public and semi-public places where the person in charge of the premises has been deemed to have a general duty to protect people on the premises from harm.[200]

B. *Nuisance*

Several authorities have suggested nuisance theories as a possible remedy for the nonsmoker.[201] The private nuisance tort is probably of little use in this context[202] because of its definition as "a nontrespassory invasion of another's interest *in the private use and enjoyment of land*."[203] In the normal situation where the nonsmoker is seeking relief from tobacco smoke in public places, the use and enjoyment of his land will not be involved.[204] One commentator has suggested, without citing authority, that an interest in a seat at a sports event or theatrical performance might be considered a limited property interest worthy of protection by private

198. 145 N.J. Super. at 526, 368 A.2d at 413.
199. Donna Shimp's lawyer emphasizes the importance of choosing a judge who is "innovative and fearless and not hesitant to make new law if the evidence warrants it." SHIMP BOOK, *supra* note 46, at 45. He also feels it is important to make a low-key presentation, showing that the case is simply one involving a worker's right to a healthy environment based on the medical evidence presented. *Id.*
200. BRODY, *supra* note 31, at 82.
201. *Id.* at 83-86; *Ire*, *supra* note 44, at 81-86; *Non-Smoker*, *supra* note 15, at 155-57; Comment, *Toward Recognition of Nonsmokers' Rights in Illinois*, 5 LOY. CHI. L.J. 610, 618-22 (1974).
202. *See Ire*, *supra* note 44, at 82.
203. RESTATEMENT (SECOND) OF TORTS § 821D (1979) (emphasis added).
204. In a few unusual situations, the use or enjoyment of land would be impaired by cigarette smoke. For instance, a nonsmoker might suffer a health impairment when his neighbors in an apartment building smoke heavily. *See Ire*, *supra* note 44, at 82 n.97. The plaintiff would have to show, however, that the quantity and probability of harm outweighs the utility of the conduct. RESTATEMENT (SECOND) OF TORTS §§ 822, 829 (1979).

nuisance law.[205] A nonsmoker in Missouri may have a better chance of success than those in most states because Missouri has a special line of cases that do not require the *use of land* as an element of private nuisance.[206] A private nuisance action by a nonsmoker against a smoker would nonetheless be a case of first impression and the outcome is highly uncertain.

The nonsmoking plaintiff seems to have a better chance of recovery under the public nuisance theory.[207] Several states specifically designate smoking in public as a public nuisance.[208] Other statutes describe smoking as a health hazard.[209] In these states, a cause of action for public nuisance can surely be brought; the question would be *who* could bring the suit. Most states have a broad statute defining a public nuisance as "any activity which interferes with the health and comfort of the public."[210] Under these statutes, the plaintiff will have to show tobacco smoke is a health hazard sufficiently substantial and unreasonable to constitute a public nuisance.[211] If the smoking was done in a place prohibited by statute, however, the statute would be persuasive evidence of the unreasonableness of the act.[212] Because forty-seven states list at least one place where smoking is prohibited,[213] the public nuisance theory would seem to be available in most states.

The principal problem with using the public nuisance theory is the widely accepted limitation that a public nuisance claim may only be brought by a public official acting on behalf of the public and not by a private individual.[214] Thus, the nonsmoker should first contact a local prosecutor, the attorney general or designated health officials and try to persuade one of them to bring the suit. Failing that, the individual himself might be able to bring the public nuisance action. A private individual is allowed to bring a public nuisance action if he can show he suffered damage peculiar to himself and not shared in common by the rest of the public.[215] Thus, the typical nonsmoker whose only injury is eye and nasal irritation might not be able to bring a public nuisance claim because his injury is arguably not different in kind from that of others.[216] According

205. BRODY, *supra* note 31, at 83.
206. *See* cases cited in Comment, *The Law of Private Nuisance in Missouri*, 44 MO. L. REV. 20, 23 n.12 (1979) (criticizing these cases as inappropriate applications of nuisance law).
207. *See generally Ire*, *supra* note 44, at 82; *Non-Smoker*, *supra* note 15, at 156.
208. *See* note 67 *supra*.
209. *See* note 66 *supra*.
210. *Ire*, *supra* note 44, at 82, *citing* Arizona, California, Oklahoma, and South Dakota statutes.
211. *Id.* at 81-82.
212. *Id.* at 83, *citing* 58 AM. JUR. 2d *Nuisances* § 30 (1971).
213. *See* notes 57-63 and accompanying text *supra*.
214. W. PROSSER, *supra* note 191, at 586-87. One commentator speculates that special injury may no longer be required. Comment, *Toward Recognition of Nonsmokers' Rights in Illinois*, 5 LOY. CHI. L.J. 610, 621 (1974).
215. W. PROSSER, *supra* note 191, at 586; Comment, *The Law of Private Nuisance in Missouri*, 44 MO. L. REV. 20, 31 (1979).
216. *Ire*, *supra* note 44, at 85.

to the *Restatement of Torts*, however, "when the public nuisance causes personal injury to the plaintiff, the harm is normally considered different in kind from that suffered by other members of the public and the tort action may be maintained."[217] Moreover, even if the minor eye and nasal irritation is not considered different in kind, individuals who suffer heart, lung, or allergic conditions undoubtedly suffer an injury different in kind from the general members of the public.[218]

The remedies available under nuisance theories include damages and injunctive relief.[219] The plaintiff may recover damages for the injury to his health, plus the value of any personal discomfort or inconvenience that he has suffered.[220] As a practical matter, however, these damages might only be nominal.[221] The availability of an injunction is probably more valuable to the nonsmoker.[222] Although enjoining an individual who smoked in a public place from doing so again might be an inefficient method for dealing with smoking in public under many circumstances,[223] an injunction might be the perfect remedy in cases involving the workplace or elevators, where the same smoker constantly comes into contact with the plaintiff.[224] The *Restatement of Torts* provides that the public official is not the only party who can bring a suit for injunctive relief: a person who has suffered damages different from those suffered by other people may also seek an injunction.[225]

At least one suit has been brought in which the nonsmoking plaintiff claimed public smoking was a public nuisance. In *Stockler v. City of Pontiac*,[226] the plaintiff, a pipe smoker and season ticket holder for Detroit Lions games, brought a public nuisance suit in his own name and in the name of the state of Michigan.[227] He claimed that smoking during events in the 80,000-seat Pontiac Silverdome Stadium violated a local fire ordinance and constituted a public nuisance. The court heard medical testimony and other evidence and found that smoking in the stadium constituted a public nuisance. The court issued a writ of mandamus ordering the city to abate the nuisance by prohibiting smoking and the sale of cigarettes within the facility. The city obtained a stay of the writ and the suit was ultimately settled. The out-of-court settlement agreement

217. RESTATEMENT (SECOND) OF TORTS § 821C, Comment d (1979). *See also id.*, Comment d, Illustration 2.
218. *Ire*, *supra* note 44, at 85.
219. W. PROSSER, *supra* note 191, at 602.
220. *Id.* at 603.
221. *Ire*, *supra* note 44, at 85.
222. *Id.*
223. BRODY, *supra* note 31, at 85; Comment, *Toward Recognition of Nonsmokers' Rights in Illinois*, 5 LOY. CHI. L.J. 610, 621 (1974).
224. *Ire*, *supra* note 44, at 86.
225. RESTATEMENT (SECOND) OF TORTS § 821C, Comment j (1979).
226. No. 75-131479 (Cir. Ct. Oakland County, Mich., Dec. 17, 1975).
227. *See* SMOKING DIGEST, *supra* note 39, at 88; *Ire*, *supra* note 44, at 88 n.111.

bans smoking in the stands, but permits it in concourse areas, restrooms, and private boxes.[228]

C. *Battery*

A cause of action for battery is another possibility for the nonsmoker in his legal conflict with the smoker. The results of a battery suit will largely depend on the facts of each case. In the blatant example where the smoker blows smoke directly into the face of the nonsmoker and says, "I can afford to pay the fine!," a battery action will lie.[229] In other cases where the smoker is quietly smoking and the nonsmoker across the aisle becomes ill, the result is more questionable.[230]

The *Restatement of Torts* states the elements of battery as: (1) intent to cause a harmful or offensive contact, plus resulting (2) harmful or offensive (3) contact.[231] In order to succeed in a claim for battery, the nonsmoker must establish three propositions: (1) breathing tobacco smoke is a contact; (2) such contact was harmful or offensive; and (3) the smoker intended the consequences of his act.

Exposure to cigarette smoke probably meets the requirement of a "contact." There is no question that the particles of smoke do in fact come into contact with the person of the nonsmoker.[232] In fact, studies show that because of the comparative chemistries of the human body and cigarette smoke, the smoke is actually attracted to human bodies like metal shavings to a magnet.[233] Battery does not require direct application of force by one person to another.[234] It is enough that the defendant has set into motion a force that ultimately produces the result.[235]

Exposure to cigarette smoke probably meets the requirement of a harmful or offensive contact. At least one case,[236] several legislative bodies,[237] and extensive medical evidence[238] have recognized involuntary exposure to cigarette smoke as dangerous to the nonsmoker. Even if it were not dangerous, the contact would likely be offensive, particularly since 75% of nonsmokers find it annoying to be around a smoker.[239] Ordinary contacts that are "customary and reasonably necessary to the common intercourse of life, such as a tap on the shoulder to attract attention, a friendly grasp of the arm, or a casual jostling to make a

228. SMOKING DIGEST, *supra* note 39, at 88.
229. This was the fact situation of the Sabina Shalom incident, in which the smoker was prosecuted under a state law, rather than being sued for battery. *See* notes 125 & 126 and accompanying text *supra*.
230. *Ire*, *supra* note 44, at 88.
231. RESTATEMENT (SECOND) OF TORTS § 13 (1965).
232. *See Ire*, *supra* note 44, at 87.
233. BRODY, *supra* note 31, at 32.
234. W. PROSSER, *supra* note 191, at 34.
235. *Id.* at 35.
236. *See* notes 184-200 and accompanying text *supra*.
237. *See* notes 66-71 and accompanying text *supra*.
238. *See* notes 37-49 and accompanying text *supra*.
239. *See* note 52 and accompanying text *supra*.

passage,"[240] on the other hand, have been held not to be offensive touchings. Smoking, though, is certainly not reasonably *necessary* to the common intercourse of life,[241] and the effects of smoking appear to be more serious than the slight jostlings mentioned by Dean Prosser. Nonetheless, a jury might find the particular plaintiff involved did not suffer an offensive contact. A stronger showing on this issue could, of course, be made by a plaintiff who is one of the 34 million Americans allergic to tobacco smoke.[242]

The most difficult element to prove in the battery case would be the smoker's intent to commit the battery. All consequences that the actor *desires* to bring about are intended.[243] Thus, the smoker who blows smoke in the face of the nonsmoker is guilty of battery and is liable for any actual damages, even those that are unforeseeable,[244] and may be liable for punitive damages as well.[245] Intent is not limited to consequences that are desired, however. "If the actor knows that the consequences are certain, or substantially certain, to result from his act, and still goes ahead, he is treated by the law as if he had in fact desired to produce the result."[246] Thus, a smoker who knew involuntary smoking was harmful or offensive to nonsmokers would be liable for smoking around them. A smoker who honestly did not know of the danger would probably not be liable. If the nonsmoker notifies the smoker that breathing second-hand smoke makes him ill, it would seem the smoker should no longer be able to plead ignorance.[247]

Battery has been involved in a few colorful nonsmokers' rights cases. In Sidney, Australia, a smoker who intentionally blew smoke into the face of a nonsmoker was found guilty of assault and fined $298.[248] In North Carolina, a postman made numerous complaints to his superior about the

240. W. PROSSER, *supra* note 191, at 37.
241. The *Shimp* court said: "There is no necessity to fill the air with tobacco smoke in order to carry on defendant's business, so it cannot be regarded as an occupational hazard which plaintiff has voluntarily assumed in pursuing a career as a secretary." 145 N.J. Super. at 523, 368 A.2d at 411.
242. *See* text accompanying note 44 *supra*. *But see* McCracken v. Sloan, 40 N.C. App. 214, 252 S.E.2d 250 (1979). *See* notes 249-56 and accompanying text *infra*.
243. RESTATEMENT (SECOND) OF TORTS § 8A, Comment b (1965).
244. W. PROSSER, *supra* note 191, at 35. As a practical matter, the damages will often be too small to pay the cost of the suit. BRODY, *supra* note 31, at 78.
245. W. PROSSER, *supra* note 191, at 35.
246. RESTATEMENT (SECOND) OF TORTS § 8A, Comment b (1965).
247. Brody & Brody would go a step further: "In fairness, a nonsmoker should not be required to object to a smoker in order to establish a battery." BRODY, *supra* note 31, at 77. The *McCracken* court, however, took the opposite view: "In examining the plaintiff's claim, we observe that it has been said 'it may be questioned whether any individual can be permitted, by his own fiat, to erect a glass cage around himself, and to announce that all physical contact with his person is at the expense of liability.'" 40 N.C. App. at 217, 252 S.E.2d at 252 (citing W. PROSSER, *supra* note 191, at 37).
248. AMERICAN LUNG ASSOCIATION OF WESTERN MISSOURI, SMOKING AND HEALTH REPORT (Oct. 1978).

adverse health effects he had suffered at work from tobacco smoke in the work environment. He finally asked for a sick leave because of his allergy to the smoke.[249] The supervisor denied the request and summoned the postman to a meeting to discuss the problem. The supervisor smoked a cigar at the meeting, and the postman became ill and had to miss work and seek medical care. The postman filed suit seeking actual damages of $5,000 and punitive damages of $10,000.[250] Although a doctor had testified that the plaintiff had "severe respiratory problems when around cigarette smoke," the court held in *McCracken v. Sloan*[251] that there had been no competent evidence presented that the plaintiff suffered a physical illness from exposure to cigar smoke. The court stated:

> We express no opinion as to what the result would be if there were evidence of some physical injury, but on the facts of this case we cannot hold it is an assault or battery for a person to be subjected either to the apprehension of smelling cigar smoke or the actual inhaling of the smoke. This is an apprehension of a touching and a touching which must be endured in a crowded world.[252]

The *McCracken* court arguably made two mistakes. First, the court seemed to consider aggravation of an allergy to be a totally insignificant harm. Actually, allergies to cigarette smoke can involve serious symptoms,[253] and the record before the court included expert testimony that the plaintiff suffered *"severe respiratory problems* when around cigarette smoke."[254] Even if causing severe respiratory problems is not physical harm, it certainly could be considered an offensive touching. The court's second mistake, therefore, was requiring plaintiff to show a physical illness in order to prove battery. Tort law in most jurisdictions,[255] including North Carolina,[256] recognizes an offensive touching as sufficient.

D. *Intentional Infliction of Mental Distress*

The intentional infliction of mental distress tort has been mentioned as a possible remedy available to the nonsmoker.[257] Although at first glance the tort does not seem to apply to smoking conflicts, closer examination reveals certain circumstances in which a plaintiff should be allowed this cause of action.

To recover under a theory of intentional infliction of mental distress, a plaintiff must show that the extreme and outrageous conduct of the

249. McCracken v. Sloan, 40 N.C. App. 214, 252 S.E.2d 250 (1979).
250. *Ire, supra* note 44, at 89 n.129.
251. 40 N.C. App. at 215, 252 S.E.2d at 251.
252. *Id.* at 217, 252 S.E.2d at 252.
253. *See* notes 43-45 and accompanying text *supra*.
254. 40 N.C. App. at 215, 252 S.E.2d at 251 (emphasis added).
255. *E.g.*, Stowers v. Ardmore Acres Hosp., 19 Mich. App. 115, 126, 172 N.W.2d 497, 502-03 (1969); 6A C.J.S. *Assault & Battery* § 8 (1975).
256. Ormond v. Crampton, 16 N.C. App. 88, 191 S.E.2d 405, *cert. denied*, 282 N.C. 304, 192 S.E.2d 194 (1972).
257. *Ire, supra* note 44, at 89.

defendant has caused him to suffer emotional distress.[258] Bodily harm is not required. The emotional distress might include "all highly unpleasant mental reactions, such as fright, horror, grief, shame, humiliation, embarrassment, anger, chagrin, disappointment, worry, and nausea."[259]

In the majority of nonsmokers' rights cases, the requirement of "extreme and outrageous conduct" would probably not be met. The *Restatement of Torts* states it is not enough that an act be inconsiderate and unkind. Rather, the *Restatement* would impose liability only where the conduct of the defendant has been so atrocious and utterly intolerable that the average member of the community would view the conduct and exclaim, "Outrageous!"[260] The cases where cigarette smoking in public can truly be considered "outrageous" are few.

Comment f to section 46 of the *Restatement* explains that the extreme and outrageous character of the conduct may arise from the defendant's knowledge that the plaintiff is peculiarly susceptible to emotional distress, by reason of some physical or mental condition or peculiarity. "The conduct may be heartless, flagrant, and outrageous when the actor proceeds in the face of such knowledge, where it would not be so if he did not know."[261] For example, suppose the plaintiff were a nonsmoker who was often bothered by smoking at his workplace. He had complained to his supervisor about the problem, and his supervisor was well aware of plaintiff's aversion to cigarette smoke. Plaintiff was made sick at work by the smoke and he went to the hospital. The supervisor visited the plaintiff in the hospital room and blew smoke in his face. In these or similar circumstances, the average member of the community might well exclaim, "Outrageous!," and a cause of action for intentional infliction of mental distress would lie.[262]

E. *Strict Liability*

It has been suggested that the smoker should be held strictly liable for the injury he inflicts on the nonsmoker under the "abnormally dangerous activity" doctrine.[263] Under this theory, a person who carries on an abnormally dangerous activity is subject to liability for resulting harm to the plaintiff, if the harm is the kind of harm that made the activity dangerous in the first place.[264] The paramount question in nonsmokers' rights cases brought under this theory would be whether tobacco smoking should be considered an abnormally dangerous activity.

258. RESTATEMENT (SECOND) OF TORTS §§ 46-47 (1965).
259. *Id.*
260. *Id.*
261. *Id.*
262. *See* RESTATEMENT (SECOND) OF TORTS § 46, Comment f, Illustration 12 (1965); *Cf.* notes 249-56 and accompanying text *supra* (the *McCracken* fact situation, *see* text accompanying notes 249 & 250 *supra*, arguably presents an intentional infliction of mental distress).
263. BRODY, *supra* note 31, at 93-95.
264. RESTATEMENT (SECOND) OF TORTS § 519 (1977).

The *Restatement of Torts* lists several factors to consider when determining whether an activity is abnormally dangerous, including: (1) the existence of a high degree of risk of a great harm to others; (2) the inability to eliminate the risk even by the use of reasonable care; (3) whether the activity is a matter of common usage; (4) whether the activity is appropriate to the place it is done; and (5) the extent to which its value to the community is outweighed by its dangerous attributes.[265] All six factors do not have to be present in order for liability to be found, but all are of importance.[266]

In applying these factors to the nonsmokers' rights setting, the prospects for successful use of this theory seem remote. One factor that would be insurmountable in most cases would be the requirement of "great harm." Although the *Restatement* mentions nuclear explosions[267] and the like, persons suffering heart or lung disease might meet the requirement, as might children.[268] In the nonsmokers' favor are the facts that there would be a high risk of harm to nonsmokers, the smoker cannot make the smoke less dangerous by the use of reasonable care, smoking is inappropriate in many enclosed indoor places, and smoking has little value to the community as compared to its danger to involuntary smokers. When all of the factors are considered, even though each does not have to be met, it would seem the nonsmoker would rarely have a good cause of action under this theory. As Professor Brody suggests, however, "Smoking in the intensive care unit of a hospital may well be 'abnormally dangerous.' "[269]

F. *Product Liability*

An analysis of the product liability suits against tobacco companies is somewhat beyond the scope of this Comment. It might be important for the nonsmoker to keep in mind, though, that at one time during the late fifties and early sixties, when the link between cigarette smoking and cancer was suspected but not proven, several cancer victims brought product liability actions against cigarette companies.[270] Without exception, these suits failed. In the mid-sixties, legal commentators felt suits against tobacco companies would never overcome the assumption of the risk doctrine, since the smoker knew just as much about the alleged danger of smoking as did the tobacco companies.[271]

Product liability suits might well enjoy a revival, however, as a result of the mounting evidence that involuntary smoking is harmful to innocent

265. *Id.* § 520.
266. *Id.*, Comment f.
267. *Id.*, Comment g.
268. BRODY, *supra* note 31, at 91; *see* notes 39-42 and accompanying text *supra*.
269. BRODY, *supra* note 31, at 94.
270. For a collection of cases and articles dealing with the product liability suits against tobacco companies, see W. PROSSER, *supra* note 191, at 660 nn. 82 & 83.
271. *See* Wegman, *Cigarettes and Health: A Legal Analysis*, 51 CORNELL L.Q. 678, 719-21 (1966); Comment, *Can Cigarettes Be Merchantable, Though They Cause Cancer?*, 6 ARIZ. L. REV. 82, 91 (1964).

bystanders near a smoker.[272] Innocent bystanders, unlike smokers, do not assume the risk. Modern tort cases have allowed bystanders to recover in product liability cases.[273] Nevertheless, many difficulties would be encountered in such a suit: the plaintiff must convince the court to follow the cases allowing a bystander to recover; the plaintiff must establish that tobacco products are legally defective; the plaintiff must establish that the tobacco product was a substantial factor in the cause of his injury; and the plaintiff must convince the court that his claim is not frivolous.[274]

VII. CONCLUSION

Less than a decade has passed since the 1972 Surgeon General's report warned that cigarette smoke could be dangerous to nonsmokers who breathe it involuntarily. As recognition of the danger to nonsmokers has increased, the movement to solidify the rights of nonsmokers to be free from the danger has also increased. State legislatures and courts should be given credit for reacting fairly quickly to this significant health hazard. At the present time, only fourteen states have not yet enacted a regulation or statute giving some protection to nonsmokers. Although constitutional arguments have failed so far, nonsmokers have had some success with tort claims, particularly in the workplace situation. During the last decade, nonsmokers have tested the water in a new area of law, with the clear result that legal remedies now exist for the nonsmoker who cares enough about his rights to seek legal help.

MORLEY SWINGLE

272. One lawyer who evidently feels such a revival is possible is Melvin Belli, who is reportedly eager to find the right case. READER'S DIGEST, Feb. 1980, at 105.
273. *See, e.g.*, Elmore v. American Motors Co., 70 Cal. 2d 578, 451 P.2d 84, 75 Cal. Rptr. 652 (1969).
274. These issues are examined in BRODY, *supra* note 31, at 90-95.

II

AMERICAN LUNG ASSOCIATION OF MONTANA

Christmas Seal Bldg. — 825 Helena Ave.
Helena, MT 59601 — Ph. 442-6556

EARL W. THOMAS
EXECUTIVE DIRECTOR

STATEMENT OF STEPHEN BALAZS, PROGRAM CONSULTANT FOR THE AMERICAN LUNG ASSOCIATION OF MONTANA, BEFORE THE HOUSE PUBLIC HEALTH COMMITTEE, FEBRUARY 20, 1981, ON HB 794

Enforcement is the necessary component that makes legislation work. Without adequate enforcement, or procedures for upholding them, laws are nothing but eloquent writing on pieces of paper.

Because of its lack of enforcement and provisions for penalties, Montana's present Clean Indoor Air Act of 1979 is an anemic enigma, laughable with non-compliance. It has become a toy teapot in a tempest some say is overburdened with regulations.

But laws which empower the state or individual communities to protect the health, safety, or morals of its people are neither unconstitutional, without precedent, or an abuse of civil authority when such laws "are not arbitrary or discriminatory, and if the requirements of due process are satisfied. [1]"

The American Lung Association of Montana, therefore, supports HB 794, which upholds the right of Montanans to breathe air unpolluted by tobacco smoke in certain areas of public facilities or where the public gathers, and protects their health through the strength of reasonable enforcement.

Any nonsmoking (or smoking) legislation should provide a solution that is both appropriate and reasonable. Such regulations, as are contained in HB 794, are not directed against smokers (nor do they protect them from the ill effects of their own smoke), but rather, they act in favor of the health of the innocent nonsmoker and the right to breathe air unpolluted by tobacco smoke.

The U.S. Supreme Court has required that two provisions of the U.S. Constitution, the Fourteenth Amendment due process and equal protection clauses, be considered when determining the validity of statutes such as HB 794.

The enforcement and penalty provisions in HB 794, to uphold the rights of all Montanans, smokers and nonsmokers alike, in the public facilities defined in 50-40-103 (2), are neither arbitrary, discriminatory, or invalid if due process and equal protection has been considered.

As to equal protection, the Court has said:

> "The equal protection clause will be violated where the legislature makes impermissably discriminatory or arbitrary classifications under a police power statute. It seems unlikely that a valid substantive argument can be made that restrictions on smoking in public places deny to the smoker the equal protection of the laws, or that singling out smokers for regulation to minimize the health hazard of tobacco smoke is an invalid legislative classification. [2]"

Aside from the philosophic and legalistic arguments that might be welghed into HB 794, are the increasing medical and scientific data documenting the serious health problems associated with involuntary smoking which is not really the chief concern of HB 794, but neither which should be ignored.

However, the majority of taxpaying Montanans who are nonsmokers and considerate smokers don't really like the idea of supplementing their air or food in public areas or at public meetings, with the 4,000 or so chemical compounds contained in tobacco smoke, 90% of which are known poisons or carcinogens, because of the inconsideration of a minority of militant smokers.

Enforcing the Montana Clean Indoor Air Act is not a Republican or Democrat issue. Rather, it is a public health issue that should transcend partisanship or special interest, as it is legally within the interests of the state to be concerned with the health and safety of its people.

Rather than beat the dead horse of noncompliance into oblivion, the legislation in HB 794 is intended to free from pollution the very air that people breathe and falls clearly within the exercise of even the most traditional concept of civil authority and states' rights.

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1 Nebbia v. New York, 291 U.S. 502, 537 (1934)

2 _____, Antismoking Legislation, F. Cal. L.R._____ 185, (1974)

Washington Action Reporter
VETERANS OF FOREIGN WARS OF THE UNITED STATES

By Col. Phelps Jones
(U.S.A., Ret.)
Director, National Security
And Foreign Affairs

POW/MIAs, A Major V.F.W. Concern

Commander-in-Chief Arthur Fellwock has appointed the following to a POW/MIA Subcommittee of the National Security Committee: Lt. Gen. John P. Flynn USAF (Ret.), Chairman; Leslie M. Fry, the Rev. John Leonard, Archie Pavek, the Rev. Albert Salmon and Walter Thompson.

This action was mandated at the 81st National Convention.

In setting up this Subcommittee, the Chief provided the following guidance:

"Pursuant to a mandate from the 1980 National Convention, I am appointing you as Chairman/Member of the National Security Committee's Subcommittee on POW/MIAs.

"A roster of the full Subcommittee is attached hereto.

"This Subcommittee will meet in Washington at the Midwinter Conference concurrently with the meeting of the National Security Committee.

"The purposes of this action are: (a) to demonstrate our enduring commitment to the MIA/POW cause; and, (b) to generate and focus local energies and enthusiasms in seeking a full accounting of our POW/MIAs.

"The Director of National Security and Foreign Affairs will contact the Subcommittee Chairman and ascertain how he may advance the mission of this Subcommittee.

"For your information, I attach a report, prepared under the aegis of the Joint Chiefs of Staff, 'The Current Status on the Prisoner of War/Missing in Action (POW/MIA) issue.'

"Years of apathy, helplessness and indifference are now being swept away by new information that demands our vigilance and coordinated efforts.

"If, for any reason, any member of this Subcommittee feels he is unable to serve, please contact the Director of National Security at 202/543-2239, and I will relieve you of this duty.

"May you and your family enjoy a happy holiday season. The strong possibility persists that some Americans in Southeast Asia will be unable to do so."

The report prepared by the Joint Chiefs of Staff, referred to in the Chief's letter, follows and entitled:

THE CURRENT STATUS ON THE PRISONER OF WAR/MISSING IN ACTION (POW/MIA) ISSUE.

1. Many Americans are unaware that nearly 2,500 servicemen are still unaccounted as a result of the Vietnam war. There were 2,553 military and 41 civilian Americans unaccounted for at "Homecoming" in 1973. The military included 96 prisoners of war (POWs), 1,178 killed in action, body not recovered, and 1,279 missing in action (MIA). The civilians included 25 missing and 16 presumed dead. Since then, 74 remains have been returned and most individual cases of those unaccounted for have been administratively reviewed. Cases reviewed have invariably resulted in a presumptive finding of death, based on data accumulated in the file and the additional criteria of a lapse of time without information to indicate the individual is still living. Therefore, as of November 1980, only 14 military personnel, of those unaccounted for, have not been presumed dead. These 14 cases are broken down to one POW (USAF) and 13 MIA (11, USAF, one USN and one USMC).

2. The fact that only 14 cases remain active does not minimize the need to achieve the fullest possible accounting for the approximately 2,500 men whose fate remains in question. The debt owed to each serviceman who is unaccounted for, as well as to that individual's family is well known. Although this obligation can never be fully satisfied, the U.S. government can and should make every effort to achieve as extensive an accounting as possible. It should be emphasized that this is not just a humane gesture, but a U.S. government responsibility due every

serviceman, past, present and future.

Since the end of the Vietnam war, there has been an ebb and flow of government and public interest in accounting for Americans missing as a result of the war. The DOD POW Policy Committee, which handled the POW/MIA issue prior to the end of U.S. involvement, became inactive shortly after the U.S. withdrew form Vietnam. However, in January, 1980, an interagency group (IAG), which is comprised of representatives of the State Department, Office of the Secretary of Defense/International Security Affairs, Joint Chiefs of Staff, Defense Intelligence Agency (DIA), National Security Council, Subcommittee on Asian and Pacific Affairs/House Foreign Affairs Committee and the National League of POW/MIA Families, was established and has since been active. The main purpose of this group is to insure that priority is given to the issue and that U.S. efforts are coordinated as we continue to press for resolution of the POW/MIA issue. The IAG is continuing the work started by the JCS to develop an explicit U.S. government policy on the POW/MIA issue.

4. Although the Vietnamese claim to have released all POWs and to have been fully cooperative with the U.S. government, the facts deny this claim. The SRV has returned 72 remains and has allowed Laos to return four remains, two of which were identified as not being American. However, the Vietnamese have refused to account for Americans who were known POWs. In some cases, they have even acknowledged holding specific individuals at one time or another. These circumstances clearly belie their present claim to have fully cooperated in resolving the status of these individuals.

Of greatest concern are the receiving reports of the sightings of Caucasians currently held captive in Indochina. As more Indochinese refugees are interviewed, the frequency of live sighting reports has also increased significantly. We now have over 280 firsthand reports of live sightings under investigation. Additionally, over 170 second hand or "hearsay" reports are being investigated. Due to the number of reports of live sightings, the following U.S. government public affairs response to queries about unaccounted Americans has been formulated:

"There is an increasing number of reports that Americans may be held against their will in Indochina, but the U.S. government has thus far been unable to substantiate this information and priority effort will continue to be assigned to investigating these reports."

The increasing possibility that Americans are still incarcerated in Indochina, seven years after the war has ended, mandates immediate, high-level, U.S. government attention. One should be aware of the intelligence on this subject before forming an opinion.

6. One source testified that the SRV collected skeletal remains of Americans for many years and possessed, as late as early 1979, over 400 individual remains. Portions of this testimony have been independently verified by DIA and the witness has successfully passed polygraph tests. After first denying access to the building where the remains were reportedly stored, the Vietnammese, after several months, allowed reporters to visit the complex. As expected, no remains were found, however, DIA still considers this source valid.

7. Logically, successful resolution of the POW/MIA issue requires a number of specific actions: release of any live Americans presently being held; return of previously collected remains of U.S. personnel; search, recovery, and a cooperative effort by the U.S. and Indochinese governments in those cases where no remains exist or can be found. Additionally, fullest possible accounting requires priority attention to the issue and coordination of these efforts of all responsible U.S. government agencies, as well as active participation and cooperation of all concerned nations.

8. Although both the U.S. government and the Vietnamese government have tacitly agreed that the POW/MIA issue is humanitarian in nature and should be resolved regardless of political differences, the Vietnamese continue to link the POW/MIA issue to other considerations. History shows that the Vietnamese, in dealing with France on the return and accounting for missing French personnel, responded only when it was beneficial to their self-interests. Humanitarian ideals have had little significance therefore, a new U.S. government negotiation strategy is required. Although numerous demarches have been made to the Indochinese nations to this date, they have "stonewalled." The standard SRV response cites their inability to cooperate in search and accounting activities because their manpower is being fully utilized to defend against the threat of attack from the People's Republic of China (PRC). Recently, the Vietnamese also have stated that their people are reluctant to assist because of hostility over the "collusion" between the United States and the PRC. Although the Joint Casualty Resolution Center liaison team's recent trip to Hanoi (Oct. 1-4, 1980) had the potential for progress on the POW/MIA issue, once again, nothing of significance resulted.

9. The IAG is addressing the issues and any resulting proposed

(Continued on page 6)

Fellwock Comments On Issues

Recently, the Commander-in-Chief has publicly addressed four current national security policy issues in hard-hitting press releases, the texts of which follow:

V.F.W. LEADER URGES
"NEVER QUIT"
ON POW/MIAS

Mr. Arthur Fellwock, Evansville, Ind. national Commander-in-Chief of the 1.9 million member Veterans of Foreign Wars of the United States, cited an AP wire story which reported a sighting of a road gang of imprisoned Americans north of Hanoi by Scandinavian workers as but "the latest of a growing number of reported live sightings that must serve to redouble the determination of the American people never quit on the unresolved issue of our unreturned POW/MIAs from Southeast Asia."

(The Americans reportedly shouted in English, with American accents, "Tell the world about us.")

The V.F.W. leader urged the incoming Reagan Administration" never to permit this enduring issue of honor and compassion to be brushed aside in the press of day-to-day policy conerns."

"In Lt. Gen. Eugene Tighe, chief of the Defense Intelligence Agency and Rear Adm. Jerry Tuttle, the new Administration will find military professionals committed to, and deeply knowledgeable about, the cause of our unreturned, Fellwock commented.

"I recommend early briefings by the DIA and officials of the National League of Families to key individuals in both the incoming Administration and the 97th Congress.

"'Our hostages in Iran are approaching their 420th day of publicized captivity.

"'There may be live Americans in Southeast Asia held for more than 5,000 days.

"We must, can and will never quit."

V.F.W. LEADER FOR PARDON
OF FBI OFFICIALS

Mr. Arthur Fellwock, national Commander-in-Chief of the Veterans of Foreign Wars of the United States, today called upon President-elect Reagan to extend full, free, and absolute pardons to convicted FBI officials W. Mark Felt and Edward S. Miller "as a first order of business."

(Felt and Miller were fined a combined total of $8,500 in U. S. District Court for conspiracy for authorizing warrantless searches in the early 1970s in an effort to uncover members of the violence-prone Weather Underground.)

Mr. Fellwock recalled that President Carter promptly kept one campaign promise he made during the 1976 campagin. On his first full day in office -- Jan. 21, 1977 -- Mr. Carter granted unconditional amnesty to Vietnam-era draft dodgers. The V.F.W. leader noted that "the social and security costs associated with that shameful action are still falling due."

"As President, Ronald Reagan can spell out his values by pardoning two patriots whose crime was that they sought to prevent the overthrow of the very country Mr. Reagan is being called upon to lead," he added.

V.F.W. LEADER HITS
IRANIAN BLACKMAIL

Arthur Fellwock, Evansville, Ind., national Commander-in-Chief of the Veterans of Foreign Wars of the United States, today described as "insulting blackmail" the Iranian demand that the U.S. send or guarantee to Algeria some $24 billion to secure the release of the 52 American hostages.

"This figure, " Mr. Fellwock continued, "comes to some $460 million per hostage. It is more than the current or envisioned budget for the Veterans Administration. It is $10 billion more than the U.S. Army's current budget for operations and maintenance. It is, in short, out of the question."

The V.F.W. leader concluded by noting that "the American national interest must now be to prevent another Tehran from ever happening anywhere in the world."

"To this end, I urge President-elect Reagan, as an early order of business, not only to review the security situations of our embassies world-wide, but to make it clear beyond any miscalculation that Marine guards and all assigned military personnel will have standing orders to shoot, and shoot to kill, in defense of the embassies to which they are assigned, " he said.

"The prayers of the V.F.W. will continue unabated for the 52 hostages. I urge, however, the new Administration to keep the onus for the hostage tragedy right where

POWs

(Continued from page 5)

actions by the responsible U.S. government executive agencies, the Congress, and the POW/MIA familes. In respect to Congressional action, the Subcommittee on Asian and Pacific Affairs, House Foreign Affairs Committee, under Chairman Wolff is considering a hearing on the issue in December, 1980. It is important not to lose the momentum generated during 1980, and to maintain unrelenting pressure on the Indochinese nations, especially the SRV, with respect to resolving the POW/MIA issue.

FEB 2 3 1981

VISITORS' REGISTER

HOUSE Energy & Power COMMITTEE

BILL HB 34 Date 2-23-81

SPONSOR Ellard

NAME	RESIDENCE	REPRESENTING	SUP-PORT	OP-POSE

IF YOU CARE TO WRITE COMMENTS, ASK SECRETARY FOR LONGER FORM.

PLEASE LEAVE PREPARED STATEMENT WITH SECRETARY.

Form CS-33
1-81

Helena Medical Clinic, P.S.C.

1930 9TH AVE.
HELENA, MONTANA 59601
TELEPHONE 442-9523

The Honorable Budd Gould
Chairman, House Comm. on
Public Health

Re: HB 784

Representative Gould:

I have been involved for greater than 5 years in local planning of Emergency Medical Services. I think it is an excellent idea to establish a montana emergency medical services system. This will insure that all montanans will have quality emergency care.

Sincerely yours,
Dwight R. Hiesterman, MD

VISITORS' REGISTER

HOUSE _____ COMMITTEE

BILL _____ Date _____

SPONSOR _____

NAME	RESIDENCE	REPRESENTING	SUP-PORT	OP-POSE
Kay Tyrdal	Missoula Mt.	self		✓
Robert Stapel	Helena Mt	MMA	✓	
B Faust	Butte	MNA	✓	
Evelyn Hertz	Butte MT	MNA	✓	

IF YOU CARE TO WRITE COMMENTS, ASK SECRETARY FOR LONGER FORM.

PLEASE LEAVE PREPARED STATEMENT WITH SECRETARY.

Form CS-33
1-81

VISITORS' REGISTER

HOUSE [illegible] COMMITTEE

BILL [illegible] Date [illegible]

SPONSOR [illegible]

NAME	RESIDENCE	REPRESENTING	SUPPORT	OPPOSE
Norman Dewell	Joliet MT	Joliet EMS	✓	
[illegible]	Joliet MT		✓	
[illegible]	Harlem, MT	Blaine Cnty EMS	✓	
[illegible]	Baker MT	[illegible]	✓	
[illegible]	Roundup, MT.	self	✓	
[illegible]	Kalispell MT	Self	✓	
[illegible]	[illegible]	[illegible]	✓	
[illegible]	[illegible]	[illegible]	✓	
Lorrie Sharp	Billings, MT	Mt Basic Life Support Comm.	✓	
[illegible] Williams	Ft. Benton, Mt.	self + Chouteau Cty EMS Council	✓	
Art Bicsak	Gt Falls, MT	MEMSA	✓	
[illegible]	[illegible], MT	self	✓	
Bud [illegible]	Helena MT	Self	✓	
JOE HANSEN	BIG TIMBER MT	SWEETGRASS CO	✓	
Joan Stewart	Fort Benton	self	✓	
Dennis Henderson	Butte		✓	
Barbara [illegible]	Deer Lodge	RN.	✓	
[illegible] Bauman	Deer Lodge	RN	✓	
John [illegible]	Deer Lodge	St. MSP	✓	
James [illegible]	Billings	[illegible], YC		

IF YOU CARE TO WRITE COMMENTS, ASK SECRETARY FOR LONGER FORM.

PLEASE LEAVE PREPARED STATEMENT WITH SECRETARY.

Form CS-33
1-81

FEB 20 1981

VISITORS' REGISTER

HOUSE Public Health COMMITTEE

BILL 764 Date 2-20-81

SPONSOR Vinger

NAME	RESIDENCE	REPRESENTING	SUPPORT	OPPOSE
[illegible]	[illegible]	[illegible]		1
[illegible]	[illegible]	Self		/
[illegible]	Helena	[illegible]		—
[illegible]	Helena	Self		X
[illegible]	Helena	[illegible]		X
[illegible]	Helena	Lodden ambulance Service Helena		X
[illegible]	Helena	Montana Hospital Assn		✓
Howard Powell	Helena	St. Peters Hospital		X
[illegible]	Havre	Northern Montana Hospital		X
Glenn E Dahlberg	Butte	Silver Bow Gen Hospital		X
~~Joanne Todd~~	~~Billings~~	~~Billings Deaconess Hosp~~		
[illegible]	Helena	MSP		X
Robert Feare	Helena	MHP		X
Mike Anderson	Belgrade	Senate Dist 46		X
Brian Kelly	Great Falls	Red Cross	X	
Donna Small	Billings	MNA	X	
[illegible]	Butte	EMT/Med		
Gerald Locke	Whitehall	E.M.S. Region 3B	X	
John McPherson	Butte	Self		✓
Jan Johnson	Deer Lodge	RN	✓	

IF YOU CARE TO WRITE COMMENTS, ASK SECRETARY FOR LONGER FORM.

PLEASE LEAVE PREPARED STATEMENT WITH SECRETARY.

Form CS-33
1-81

794

Testimony for House Bill 794--Indoor Clean Air

My name is David Maughan, and I represent myself. I live in Helena, Montana at 1516 Broadway. I testify for HB 794.

Presently I work in the Air Quality Bureau for the State Department of Health. Last summer 16 of approximately 20 Air Quality Bureau workers signed a petition to have the Bureau posted as a Non-Smoking area as many other state agencies and bureaus are. But our bureau chief would take no action. This winter with a new Air Quality Bureau chief many of us asked to have portions of the work area designated non-smoking--again no action.

I tried to work within the system but asking our division administrator and then the deputy department director did not help. Our administrator said we'd have to allow smokers an hour off so they could smoke. Both our deputy director and department director smoke, so I didn't expect them to offer much assistance, although the Deputy Director said he'd look into the problem. My bureau chief, Hal Robbins, will not take any action because he says he has no authority.

In the Air Quality Bureau I work in a carrel which has 6-foot-high walls. It affords no protection against cigarette smoke, nor is the building ventilation adequate to carry any smoke away. I even run a fan to try to drive the smoke away, but it is not effective. I go home evenings with headaches and clothes smelling of cigarette smoke. It is inconceivable to me, after writing health effects sections relative to Butte's high lung cancer rates--which are mostly resultant from cigarette smoking and secondarily to other factors--that our Air Quality Bureau will do nothing to protect the health of its workers.

On a practical basis the State Health Department and the Air Quality Bureau, which are charged with protecting human health, will do nothing with the present bill that is in effect now. Some enforeement penalty is necessary before the State Health Department will do anything to protect worker health.

Sincerely,

David Maughan

David Maughan

February 21, 19 81

FEB 2 0 1981

IV

STATEMENT of INTENT HB 764

House Bill 764 requires a statement of intent because it requires the department of health and environmental sciences to adopt certain rules to implement the provisions of the bill.

It is the intent of the legislature to fund regional emergency medical services (EMS) programs and activities as parts of a statewide EMS system. It is the intent of this act to improve training opportunities available to EMS providers. The legislature does not intend that rules be adopted which impose additional requirements upon hospitals, ambulance services, or other EMS providers.

It is the further intent of the legislature that the funds appropriated by the state be used to replace federal funds no longer available for the development of training and technical assistance to EMS providers, including volunteers who would have great difficulty in obtaining training otherwise.

The legislature also intends that the rules implement the bill in a way that minimizes the administrative costs while maximizing the provision of training and support to the regional and local providers. This will assure the very best use of state funds. Also, it is the intent that the rules adopted should act primarily to facilitate the implementation of the program. The major concern of both state and regional programs is to assist and enhance current emergency medical services.

It is the intent of the legislature that rules be adopted intthe following areas: (A) concerning the contracts with the department of health, (B) defining the roles and responsibilities of the state and the regions, (C) addressing uniform training programs, (D) concerning the EMS advisory council, and (E) governing the allocation of funds.

(A). Rules adopted concerning contracts with the department of health are intended:

(1) to state the frequency and type of training programs to be offered;

(2) to assure that the training programs are consistent with statewide standards and practice;

(3) to set a salary schedule consistent with the state pay plan;

(4) to assure that regional councils are broadly representative of EMS providers and consumers; and

(5) to assure that regional councils are responsible for personnel policies and management.

(continued)

BUDD GOULD Chairman.

STATE PUB. CO.
Helena, Mont.

February 21, 1981

Statement of Intent for HB 754 continued.

(B). Rules adopted concerning the definition of the roles and responsibilities of the state and the regions should, at the minimum, address:

(1) the training of EMS providers;

(2) fiscal administration; and

(3) prevention of duplication of efforts among state, regional, and local levels.

(C). Rules adopted concerning uniform training programs should address:

(1) the assurance of uniform training programs offered for instructors, coordinators, and students; and

(2) the provision of training programs in a readily accessible way for providers, coordinators, and instructors who choose to take such training.

(D). Rules adopted concerning the EMS advisory council should, at the least:

(1) maximize input from the regions, the EMS providers, and from the consumers; and

(2) provide significant policy direction to the department in the establishment of statewide programs and goals.

(E). Rules adopted concerning the allocation of funds should, as a minimum:

(1) in addition to the rules adopted on contracts, assure fair and equitable distribution of all funds among the EMS regions; and

(2) assure allocation in a way that maximizes the provision of training and support services while keeping administration costs to a minimum.

BUDD GOULD Chairman.

STATE PUB. CO.
Helena, Mont.

My name is Keatha Mcleod, I am from Baker, I am a Registered Nurse, and an EMT working on a volunteer ambulance service.

I represent the Montana Emergency Medical Services Association which is an organization of emergency care providers formed to stress the common needs of emergency care. The membership of this group is composed of Fire Fighters, Law Enforcement, Advanced First Aiders, EMT's, R.N.'s and Physicians.

The members of MEMSA are committed to the development of a strong state EMS system, but we can not accomplish this task by ourselves. We nee HELP!!! and we need it now. We feel that there should be a substantial effort by the state to provide an ongoing training program to complement the activities already being done. This training must be provided for all components of the EMS system. An EMS system is that which takes care of the patient from the time of initial accident or illness up to and including the hospitilization of the patient.

Our organization is not the only group of people to identify training for emergency care providers as a top priority. The Montana Extension Service conducted a broad based needs assessment of the entire state of Montana entitled "Project 80". The results of this study indicated that Montanan's as a whole feel that training of emergency care providers is one of their top priorities.

We feel very stongly that every resident of and visitor to Montana deserves to receive at least a minimum level of emergency medical care anywhere with in the boundaries of Montana. The level and quality of emergency care varies considerably across the state. While much progress has been made, we still have a long way to go, and we can not get there without strong state support.

The beginnings of this system have been implemented with federal dollars that have provided for some training and the following list of equipment and ambulances that have been purchased with local monies and federal dollars. Many of the counties that received these ambulances and equipment would not have acquired them without the federal assistance.

If this issue is not addressed soon we will lose much of the ground already gained as additional regional systems are dissolved with the elimination of

of Federal monies. The task will be greatly magnified if these systems are allowed to fade into the woodwork.

MEMBERS OF THE COMMITTEE:
TO SUMMARIZE:

1. The low population base, and large geographic distances make emergency care vital to Montanans. These same factors make the provision of training more difficult. There are 110 ambulance services in the state with numbers of calls ranging from 20 to several thousand. Low volumes of calls in rural Montana necessitate substantially increased training opportunities to maintain these peoples skills.

2. MEMSA is firmly committed to improving training activities, and we strongly convinced that House Bill #764, and its companion appropriation Bill, House Bill #759, will improve training for EMS providers through State and Regional training programs.

3. House Bill #764 is not intended to pay people to take training, to pay for their certification or to add regulations to any EMS provider. It's sole intention is to provide improved training opportunities for EMS personnel in Montana, and make better training more assessable to them. It does not take over local training, it merely assists with improving the training.

To assure that each of us, and each of you, survive an accident or an illness, we ask for your help in the passage of this Bill. We will do our part with continuing to volunteer our time; please help the state to do their part.

My name is Norman Dewell from Joliet, a small town in Carbon County. I am an Emergency Medical Technician with the Joliet Ambulance Service. I received my original training under the Department of Transportation program. The initial training was classroom lecture, with minimum practical application. My performance in the field was less than satisfactory. The EMT training program was changed and practical exposure was introduced, using programmed patients. This type of training is still in effect and produces an EMT that is capable of much better field care.

Joliet does not have a large number of incidents that allow an EMT to exercise his or her skills and remain proficient. It is mandatory that on-going training be provided for skill maintenance. A small community like Joliet does not have the resources to accomplish total training. While we do conduct local training, we must rely on resources outside the community. A regional coordinated effort will ensure we have received the needed instruction to maintain quality personnel.

The current requirements for training and certification measures these skills and this bill does not add to this criteria.

Our community was able to obtain a new modular ambulance and communications equipment under a federal EMS funded program. The culmination of trained EMTs and the new ambulance brought to our community an EMS system.

People are dependent on this system and expect the service we can now provide.

To ensure that the system continues, it is imperative that funding be provided to allow our people to receive the quality training and on-going education to sustain and improve our emergency capability.

To justify these funds, I ask myself a basic question, "What quality of care do I want if I, or a member of my family, is involved in an accident in our state?"

To support my testimony, I submit letters of support from the people of Carbon County.

BEARTOOTH

RESOURCE CONSERVATION & DEVELOPMENT PROJECT

Drawer J ◆◆ Joliet, Montana 59041 ◆◆ Phone 406-962-3571

Feb. 18, 1981

Members of the House Public Health Committee

We ask your support of House Bill 764 concerning the continuation of the Regional Emergency Medical Services Systems and for House Bill 759 that provides for the subsequent funding.

The EMS program has been very active and beneficial to our area. The network of volunteer people, such as the emergency medical technicians and ambulance drivers working with nurses, doctors, and local officials have saved many lives and prevented further injuries through their training in life support procedures. We are pleased with the dedication of the people working with this program and feel that the Regional EMS will provide guidance and training to the volunteer people in the program. The development of mutual aid plans will be beneficial to our area and state.

Thank you.

Sincerely,

Chester Schwend

Chester Schwend, Chairman
Program Committee

Sponsored by:

Carbon & Stillwater Co. Commissioners, Carbon & Stillwater Conservation Districts, and Towns of Bearcreek, Bridger, Columbus, Fromberg, Joliet and Red Lodge

[illegible]
Galt, [illegible]
Jan. 18, 1981

House Public Health Committee

Please support House Bills 757 and 764 for continuation of Regional Emergency Medical Services and funding.

EMS volunteers are dedicated people and have saved many lives. The EMS program is very important.

Thank you.

Sincerely,

Celeste Sakwood

Joliet, Montana
February 17, 1981

The Legislature
State of Montana
Helena, Montana 59601

Dear Members of the Legislature,

House Bills # 764 and # 759 will soon be brought before you for consideration and I am asking for your support on each of the bills. One of the bills defines the scope of Emergency Medical Services (EMS) and the other bill is for funding of EMS, which in the past has been funded by the Federal Government. This funding which EMS has had in the past will probably be discontinued.

I have had the opportunity of being a part of local EMS for quite a few years, first in the town of Killdeer, North Dakota where I lived for a number of years and now in Joliet, Montana. In both instances and locations neither would have been able to provide ambulance services to the respective communities without the help of the EMS program. These programs, while funded by the Federal Government, have been administered by the respective states. The funding was necessary to help provide training and equipment for communities who otherwise could not otherwise obtain supplies and equipment. In both of the services of which I have been a part, interested and dedicated men and serve on a volunteer basis after special training programs, provide care and transportation to anyone involved in accidents or severe illnesses to proper medical facilities. Should the funding cease, many of these programs would probably digress or possibly discontinue. These funds have made it possible for communities to provide at reasonable cost ambulance services available otherwise only to large metropolitian areas.

Again your support of EMS will be greatly appreciated by me as a member of a provider team and one can never tell, a user of the services.

Sincerely

Edward D. Plowman, Regph.

Edward D. Plowman, REG. Ph.
Joliet, Montana 59041

2/19/81

Members of the House Public Health Committee

I ask your support of House Bill #764 concerning the continuation of the Regional Emergency Medical Services System and for House Bill # 759 that provides for the subsequent funding.

I have had the opportunity of being a part of E.M.S. for the past six years as a volunteer on an ambulance service, a coordinator and an educator in the system. The progress I have seen has been overwhelming. Without the regional program it is evident that we will see the system digress.

Again your support of House Bill #764 and #759 will be greatly appreciated.

Sincerely,

Laurie Lannell
63 Pickwick Ct
Kalispell, Mt
59901

EDNA
EMERGENCY DEPARTMENT NURSES ASSOCIATION
Montana State Coordinating Council
REGION X

Feb. 29, 1980

To: Members of the Public Health Committee

This letter is to indicate strong support for House Bill 764

We as Emergency Department Nurses recognized the importance of a very strong training program for all aspects of emergency care. We urge you to consider favorably this proposal very carefully with respect to the commitment we all have to provide for the residents of Montana the best emergency medical care that is possible.

Sincerely,

Ann Wells

Ann Wells R.N.
Chairperson Emergency Department Nurses Association
Montana State Coordinating Council

COPIES OF LETTERS IN HISTORICAL FILE

LIGHT COPIES WOULD NOT PRINT.

WITNESS STATEMENT

NAME Dennis Popp BILL No. 764

ADDRESS Box 104 Helena DATE 20 Feb 81

WHOM DO YOU REPRESENT Self

SUPPORT _____ OPPOSE X AMEND _____

PLEASE LEAVE PREPARED STATEMENT WITH SECRETARY.

Comments:
I support the concept but I oppose the bill upon the basis of permanence, potential & possible duplication of services.

A/ A bureacracy tends to expand, so one we establish now should be the best we can design; the argument that we can save money by using the service or system set up with federal menesy is specious; the same could be said for AMTRAC and the Postal Service.

B. The potential for abuse is tremendous--the chief appoints the advisors and the regional corp officers and controls their budgets so he/she is absolute. The EMS Bureau's trustworthiness quotient isn't too good to date (operating against the enabling legislation, ignoring the advise and testimony from last session, etc) so to give them absolute power seems dangerous. (The Board of Medical Examiners is an appeals board only for medical question.)

C. Possible duplication of services; as an example, the Bureau is spending a good deal of money to "coordinate" EMS radio systems, but the State Communications office would probably do a more efficient, cheaper job. EMT training, when desired by a community, could be conducted, using the DOT training course and standards by local hospitals, local committees, colleges, etc, on a self-supporting basis. Testing, using the already-developed National Registry materials, if desired, could be conducted semi-annually, on a self-supporting basis (as is examination for Nurses, Physicians, etc registry) by the board of med examiners, MEMSA, or the Dept of Hwy Safety .

One alternative to this bill, would be study by a group of legislators to determine the most efficient system to funnel/screen/distribute the training money where it will do the most good. In the meantime, making as much as $10,000 available through the H&ES Office to help communities needing aid and desiring the particular course.

In short, this bill creats a super-bureaucracy, which must be funded, just to distribute training money, (and, through control of the funds, to control all training, certification, etc throughout the state) without any recourse by the citizens or communities involved!

FORM CS-34
1-81

WITNESS STATEMENT

NAME Evelyn Joppa BILL No. 764

ADDRESS 7993 Hwy 12W Helena DATE 2-20-81

WHOM DO YOU REPRESENT Self

SUPPORT _____ OPPOSE X AMEND _____

PLEASE LEAVE PREPARED STATEMENT WITH SECRETARY.

Comments:

Under present System no interested party can be come an EMT unless they are part of the first response groups.

Student & other interested parts are forced into joining such groups because this course is not held in Colleges or Vo ~~tech~~ tech centers.

FORM CS-34
1-81

EDGAR PUBLIC SCHOOLS
ELEMENTARY DISTRICT 33
EDGAR, MONTANA 59026
(406) 962-3439

February 18, 1981
Edgar, Montana

Emergency Medical Services
Cogswell Building
Helena, Montana 59601
Attn. Norm Dewell

Dear Sirs:

We the undersigned feel the work done by the Emergency Medical Services is invaluable in our county and we wish to express our support for its continuation and feel that some monetary support should be given this service and to the people who must keep up with their training and in the training of new people to continue this service.

Please give careful consideration to House bills #759 and 764.

Thank you for your attention to this matter.

Sincerely,
The Staff of the Edgar Elementary School Dist #33
Carbon County, Montana

Terri Hodgson
Ada [illegible]
Jackie [illegible]
Alice [illegible]
[illegible]

Judith A, Smith
Box 129
Edgar, Mt. 59026

Members of the Legislature,

I urge you to pass and support House Bills # 759 and 764 involving the Emergency Medical Service of Montana. The E.M.S. program is getting better every year due to care at state levels and because there is an organization that can reach and coordinate groups all over this large state. As possible users of the emergency care system we all benefit by the best possible system we can manage.

Sincerely,

Judith A Smith

RED LODGE CLINIC
10 SOUTH OAKS
DRAWER 1120
RED LODGE, MONTANA 59068

Telephone 446-2412

.MES J. KANE, M.D.
ENJAMIN K. KARAS, M.D.
DALE L. KEMMERER, M.D.

February 17, 1981

State Legislature
State of Montana
State Capitol
Helena, Montana 59601

To Any Interested Party Regarding House Bill No. 764 and No. 759:

We, the physicians of the Red Lodge area, being basically a rural area which is constantly in need of well qualified emergency personnel and ambulance services, heartily endorse the above two bills. We feel this is vital to maintain a good quality of medical care and would urge passage of both bills.

Sincerely yours,

Benjamin K. Karas, M.D.

James J. Kane, M.D.

Mark S. Myers, M.D.

Dale L. Kemmerer, M.D.

BKK/jr

WITNESS STATEMENT

NAME Ric Kohl BILL No. 764

ADDRESS 7890 Hoge Dr. DATE 2-20-80

WHOM DO YOU REPRESENT Lewis & Clark Search & Rescue

SUPPORT yes OPPOSE AMEND

PLEASE LEAVE PREPARED STATEMENT WITH SECRETARY.

Comments: ARE Assoc. strongly support This Bill.

FORM CS-34
1-81

2-20-81 III

MONTANA EMERGENCY MEDICAL SERVICES ASSOCIATION

Following are the comments of the MEMSA Legislative Committee concerning the utilization of Federal funding within Montana and other general comments concerning House Bill 764.

STATE OVERVIEW MONIES

These funds, after hard negotiation with federal officials, were an active effort by the State Department of Health and Environmental Sciences to assure at least some minimal assistance to areas of Montana not receiving federal funding assistance under the grant program. Federal government was not able to fund the statewide program and all of the regions, but did concede the need to help all areas. These have not been used primarily for administration, but in direct training and support services such as:

- Advanced Trauma Life Support
- EMT Instructor Programs
- EMT Course Coordinator Programs
- Practical Skills Workshops Throughout the State
- Statewide Educational Programs for Ambulance Personnel
- Technical Assistance Programs to Locals
- Montana Poison Control System
- EMT Continuing Education Programs Across the State
- Evaluation Activites
- Minimal staff Support for the Bureau for Training Functions

ANY SURPLUS REMAINING WAS GIVEN BACK TO REGIONS FOR TRAINING/OR EQUIPMENT.

- Early in the program, those monies classified as "State Overview" was the funding which went directly to the Regions. This is primarily a difficulty with semantics.

- State General Fund, in the amount of approximately $150,000 per year was used to match overview funds.

MATCHING FUNDS DOCUMENTATION

- No hard dollar match has been required from the counties to support any of the Regional staff. 100% hard dollars were contributed by federal government (the rest is "soft" match).
- MATCHING FUNDS FOR ITEMS OF EQUIPMENT UNDER GRANT FUNDS WERE 5% LOCAL DURING THE FIRST YEAR AND 25% LOCAL DURING THE SECOND YEAR. "SOFT MATCH" MADE UP THE REST AND WAS VERY VALUABLE. (AMBULANCES AND MONITOR DEFIBRILLATORS VARY IN THE MATCH RATIO)
- TOTAL FEDERAL EQUIPMENT $ = 818,564.62 (TO JUNE, 1979)
- TOTAL LOCAL EQUIPMENT $ - 448,124.55 (TO JUNE, 1979)

MISCELLANEOUS

- There is no intention to by-pass county representatives. EMS Councils, on a Regional level, provide for appointment of Representatives from Local Government to assure their involvement.
- Regional entity definition specifically written to accommodate wishes of Local Government should they wish to be directly involved with the regional system.

OTHER

- Regional entities are not just for Administrative Services - the contracts are primarily for the conduct of training activities.
- In early programs, there were not trainers. This has subsequently changed and is now more effective.
- Advisory Council is to strengthen input and to correct what may have been problems in the past. Rule making authority will be under the auspices of the administrative procedures act and is not arbitrary or cprecious.

Any legislation introduced in last session of the Legislature was concerning the EMT Certification Program. Only, not training issues or overall activities of a state and a regional EMS system.

- MEMSA stronly recognizes and encourages:
  - A strong, local committment to EMS, and in no way intends to subvert that. We wish to make training easier, and not add an additional expense to already over burden counties. They will still need to maintain a good local EMS system. This Bill is intended to assist all local EMS providers.

I

Proposed amendments for H.B. 764

1. Page 4, line 4.
   Following: "other"
   Insert: "educational"

2. Page 4, line 11.
   Following: "consists of"
   Strike: "17"
   Insert: "21"

3. Page 5, line 2.
   Following: "department;"
   Strike: "and"

4. Page 5, following line 2
   Insert: "(f) two members representing a statewide hospital association; and"
   Reletter subsequent subsection.

5. Page 5, line 3.
   Strike: "two"
   Insert: "four"
   Following: "at large"
   Insert: "who are consumers and are"

IX H

My name is Robert Shepard. I am a local physician here in Helena and I represent the Montana Medical Association. I would like to speak in favor of this bill. By doing so I would like to go back through some of the past history of the Emergency Medical Services system in Montana and explain why the current proposal takes the form that it does which may seem needlessly cumbersome and involved.

Basically, in 1974 the Department of Health was established as a lead agency for emergency medical services in the state. In 1975, as defined by federal grant criteria, the state was divided into Emergency Medical Services Regions. At that time, also, legislation allowing for certification of EMTs was passed in Montana. The first two emergency medical services regions in the state were at that time funded. There are currently six regions that are federally funded in the state; each has been funded for approximately two years. Some have ended their funding and some now are just beginning their funding period. However, within the next two years all regions will no longer be funded. The regions themselves have certain advantages; that is, each of the regions give local control and thereby local responsiveness to the emergency medical services system. To have done this by county would have been too many regions and would not have been cost effective, and to do it totally by the state would have required too large of a bureaucracy that would not have been necessarily responsive to the local areas. Therefore, the state was divided into regions. Currently the federal program has required six regions within the state; however, it is the intention of MEMSA with this legislation to convert to the Governor's Planning Regions which consists of five regions across the state.

I would like to speak to the program as it has now been set up and what is now going on. First of all, the program has been generally successful in implementing an EMS training program through the state. It has been instrumental in increasing the pass rate of EMTs in the state exam. Also, it has been instrumental in increasing the training at all levels; there's a course called the Advanced Trauma Life Support Course which is now run through some of the previous funding at a

physician level. Some 50 physicians around the state have taken this course and been trained in Advanced Trauma Life Support.

Why support this bill? Well, first of all, the mechanisms that this bill implements are already largely in place and so there will not be any new bureaucracy that will need to be set up. Secondly, this bill is directed at training and educational aspects and is not directed at increasing government regulations or restrictions of emergency medical services at its present state. Thirdly, federal funding is ending and the state needs to pick up and recognize its own responsibility as previously mentioned for the emergency care of its citizens and training of its personnel. And lastly, because the bill will work; it has already been shown that it works to improve training and education in all levels including ambulance personnel, nurses, physicians, other EMS providers, and hospital emergency rooms.

X

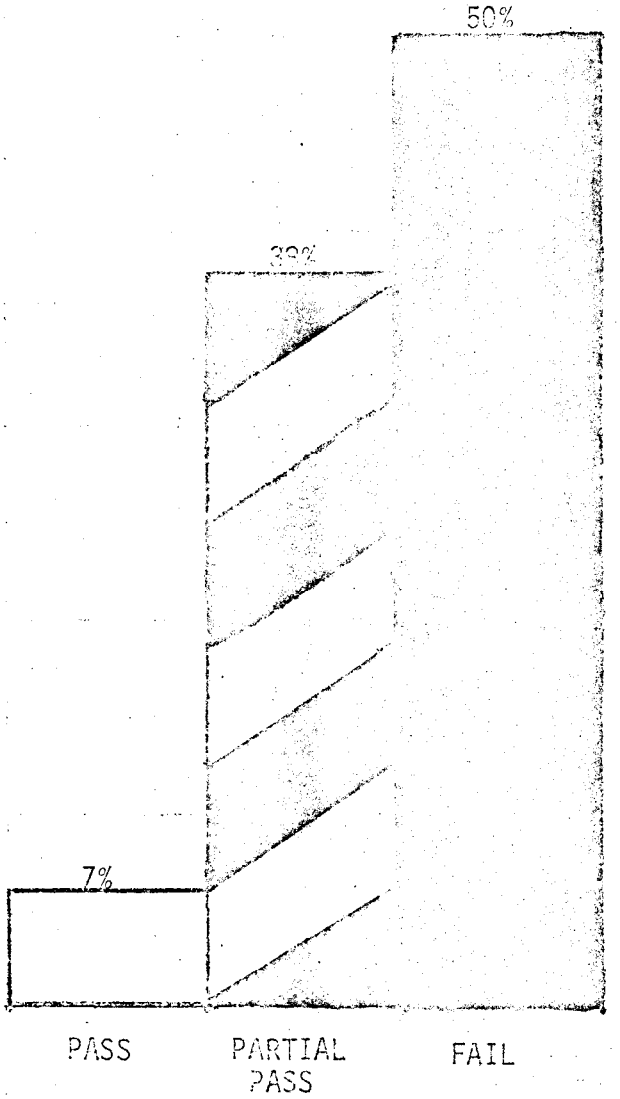
EQUIPMENT	NUMBER
Training Kit	8
Ambulance	23
Base Stations	31
Mobiles	58
Portables	71
Pagers	111
Portable Monitor/Defibrillators	17
Extrication Kit	10
Portable Suction Units	7
Mast	9
Port-O_2-System	10
Jump Kits	9
Central Dispatch	1
Meyer Othosis	22
Liquid Air	1
Miscellaneous	63

TOTAL EXPENDITURES:	Federal	Local	Combined
	$818,564.62	$448,124.55	$1,266,689.17

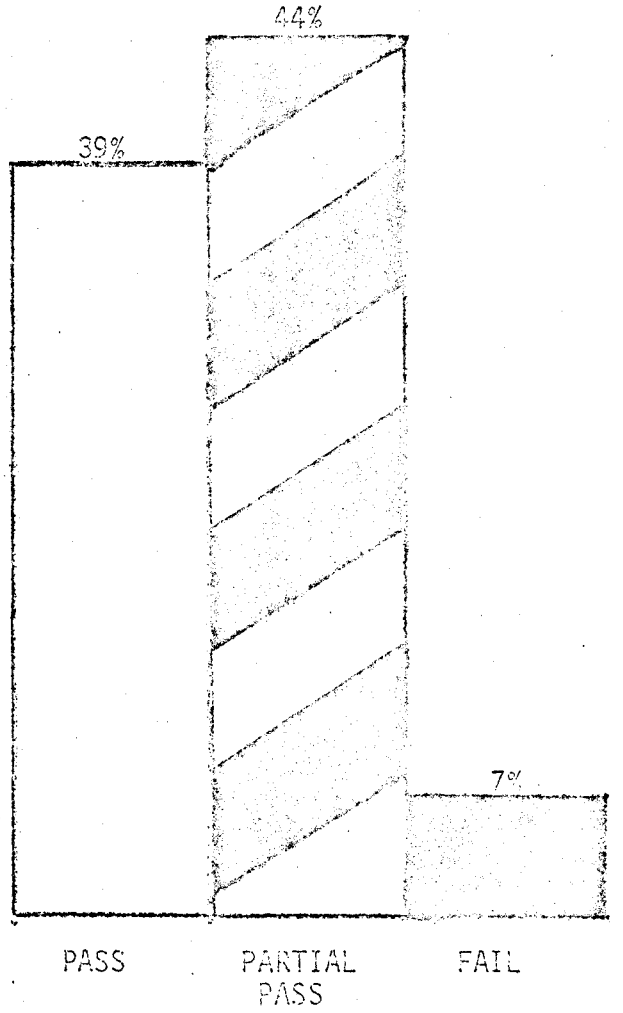
For Period: Program inseption through June, 1979.

PRACTICAL EXAMINATION RESULTS

PRE-FUNDING



POST-FUNDING



XII

The persons signing this letter are responsible for the administration of the Emergency Medical Services program at the local level in their respective Counties.

We feel that the proposed package of HB 759 and HB 764 contain serious defects that must be corrected before we could support continuation of the Emergency Medical Services program in Montana.

Specifically, we question the appropriation of funds for "Regional Medical Entities" that were not reviewed with the local governments allegedly served by these Regional Medical Entities.

Under the Federal program that is now ending, the actual cash dollars received by Regional Medical Entities represented only twenty five per cent of the cost of the program. The other seventy five percent has been provided by the local governments who have provided the foundation of the program.

It must also be pointed out that the State of Montana has not provided any dollars in the past. The State EMS Bureau in the Department of Health and Environmental Sciences has received One million, One Hundred and Seven Thousand, Seven Hundred and Seventy Seven dollars in "overview" funds since the program began. This money came entirely from Federal sources. Required "match" to make this money available came in the form of "soft" (non-dollar) goods and services. Many of these were contributed by local governments at the County level.

The money that has gone to the State EMS Bureau represents nearly one third of all the funds available since the program began. Of the other two-thirds, a large percentage went to "contracted services" or "Regional Medical Entities" for administrative purposes.

To date, the only "Regional Medical Entities" have been private non-profit corporations, not units of county government.

Our reservations regarding the proposed HB 764 include the following:

Section 1 (6) (d) gives the EMS Bureau sole authority to decide WHO will be granted "Regional EMS Entity" status. Counties--who have put up between fifty and seventy five per cent of all past funds---are given little or no voice in this selection.

Section 2 (4) calls for ongoing evaluation of "availability and quality" of EMS throughout the state. It implies that the purpose of this evaluation is to report to the advisory council. But the experience we have undergone in the past indicates this "evaluation" will be largely unilateral by the Bureau, and will be used to exert the beliefs and conclusions of the Bureau even when there are honest differences at the local level.

Section 2 (8) gives the advisory council a voice in the selection of the "Regional EMS Entity". But a review of Section 4 will show that this Council is ADVISORY only.

Section 4 (3)(c) shows how limited this Council will be. It calls for the Council to perform duties as "specified by the RULES promulgated by the department".

It must also be pointed out that County Commissioners, who are expected to approve local funds and programs, are given no voice at all in the selection of Advisory committee members.

Section 5 confirms our fears. This section gives the EMS Bureau a completely free hand in adopting all rules and in GOVERNING THE ALLOCATION OF FUNDS. It does provide for "consultation with EMS providers".
What about consultation with those providing the bulk of the funds: local government?

Please be assured that all of us have a firm committment to Emergency Medical Services. This committment is reflected in the programs our Counties have developed with a tiny percentage of the three and three quarters of a million dollars the State has received from the Federal government, plus a large amount of local funds. But our committment also requires us to question funding a program that primarily continues a "framework" but makes no mention of the funding and support required by local (County) government.
Our experiences with the unmet deadlines, conflicting rulings, arbitrary allocations and other problems of the past give us misgivings about the "blank check" the Legislature is giving the

EMS Bureau in this legislation.
There has been a growing amount of dissention amongst those involved in the EMS system over the past few years.
During the 1978 Legislature, this dissention resulted in a proposal to eleminate the EMS Bureau. That proposal led to a "fact finding" tour of the state by then-Director Knight and his Division Chief George Fenner.
The results of their tour were never revealed, as the Legislature ended without action on the proposal.
Naturally, in any dispute or disagreement there are points to be made in favor of all participants.
We do not seek the destruction of the EMS program.
We realize that failure to adopt HB 759 will result in the elemination of the program due to lack of funds.
But we also feel we cannot support a proposal that merely continues the "status quo" and avoids confrontation of the basic issue: the lack of direct, decision making input by the County Governments that must fund all programs when State and Federal funds run out.
We therefor propose that the funding bill, HB 759, be amended to provide adequate funds for maintaining the EMS Bureau in Helena, but that funding of the "Regional EMS Entities" be eleminated.
Retention of the Bureau would provide a basic core group to provide continuity of the program while the second phase of our proposal is implemented.
This "second phase" is essentially as follows:

The Legisislative Council cause hearings to be held during the Interim, addressing the following questions:

1. What are the long-term EMS needs of the State?
2. What is the proper "mix" of state and local funds necessary to meet these needs?
3. What is the most effective administrative structure to meet the needs and administer the funds?

Prepare necessary legislation for the 1983 Session to establish the long term structure for delivery of services.
As there are sufficient Administrative Rulings at present to maintain the EMS Bureau, HB 764 should be rejected.

We, the undersigned, support the testimony contained in the attached "Testimony regarding HB 759 and HB 764":

Wilma L Smith	Silver Bow County
Jack Tolmoo	Silver Bow County
John D McPherson Jr	Silver Bow County
William E Murray	CASCADE COUNTY
Wm S Pettit	Flathead County

XIII

Emergency Services
Mike Anderson

Feb. 19, 1981

Dear Mike Anderson

After reading House Bill #764 and reviewing the Montana Emergency Medical Service Association Legislative Proposal to the Montana Legislature, I felt it necessary to express some of the concerns we feel about this piece of legislation.

First I would like to establish that I am not opposid to Emergency Medical Services. My position, as dispatcher for the Whitehall Police Dept, Fire Dept, Search & Rescue and ect, makes me aware of how important these services are to the people in our Community and to the general public. What I am opposid to is this bill which I believe will establish a doom type service, in which those that don't belong (or join) won't work. I feel this bill which gives unlimited power to establish, control & implement statewide control over ambulance personel, EMT's, first responders (which would include Police, Firemen, Search & Rescue, Highway Patrol) Physicans, nurses & all other types of health providers; will eventually

destroy our volunteer system which is so necessary in small communities such as ours.

I would like to bring to your attention a conversation I had with Ken Boster, who is associated with the EMS Bureau, a few years back. Myself and a couple of members of our ambulance service were discussing with him, the direction the EMS Bureau was taking & how detrimental Federal Criteria & requiring EMT's Nat'l. Certification would be to already established localized ambulance services such as ours. He stated that when he came to Montana there were a couple of thousand so called Certified EMT's & it was their intent to weed out some of these local yokels & develope a more select group of professionals. Well he certainly succeeded in doing that as our certified EMT. felt the sacrifice they would have to pay was too great to be Nat'l Certified. They felt even if they went through the whole process, one which they had already completed, the requirements in keeping the Certification current would result in possible job loss & business problems. So they decided

Many are already upgrading their certification — to take the only option available and regress to an Advance First Aid card. This was done by putting in an additional 80 hrs of repetitious training. This was done again, as was their original EMT Certification on their own time and expense so they could keep our ambulance operational. The point I am trying to make is the inflexible attitude displayed by an important member of the EMS Bureau, who had a great deal to do with the policy making of a department, reflects an attitude of indifference by the EMS. Bureau, by ignoring the needs of localized area's, the wishes of a number of EMT's which wished to remain on a state level and the legitimate concerns of providing Emergency services in a largely rural state, the bureau instead implemented policy which required all Montana EMT's to be nationally Certified & made Montana one of the first states to require this.

These feats were all made possible by the Legislature giving the EMS Bureau the authorization to confer & cooperate with our local agency. I hope you can realize the concern we now have

with this proposed Bill # 764 which would authorize statewide control and allow them to dictate policy for all emergency agencys in the State of Montana. Thus giveing them the leverage to withhold training and funding and forcing ~~mandatory~~ mandatory compliance of their policys & criteria are not met.

I strongly urge your support in killing a bill which will be detrumental to ambulance services in rural areas.

Sincerely
Gail Guns
Whitehall, Mt.

Give the bill a hearty "Do not Pass"

Part 1

Ambulance Services

7-34-101. Ambulance services authorized. A county, city, or town, acting through its governing body, may establish and maintain an ambulance service for such county, city, or town. Any county, city, or town may contract with any county, city, or town to establish and maintain a joint ambulance service and to share the costs of such costs to be apportioned according to the benefits to accrue, with the proportion to be paid by each to be fixed in advance by joint resolution by the respective governing bodies, if the governing body has received a petition signed by 15% of the electors registered to vote in the county, city, or town at the last preceding general election or in each of the counties, cities, or towns wherein a joint ambulance service is being established.

History: En. Sec. 1, Ch. 238, L. 1961; amd. Sec. 1, Ch. 162, L. 1967; R.C.M. 1947, 69-3601(part).

7-34-102. Special mill levy permitted. In addition to all other levies authorized by law, each county, city, or town may levy an annual tax up to 1 mill on the dollar of the taxable value of all taxable property within the county, city, or town to defray the costs incurred in providing ambulance service.

History: En. Sec. 1, Ch. 238, L. 1961; amd. Sec. 1, Ch. 162, L. 1967; R.C.M. 1947, 69-3601(part).

7-34-103. Manner of providing ambulance service. If a county, city, or town establishes or maintains such ambulance service it may, acting through its governing board:

(1) operate the service itself or contract for such service;

(2) buy, rent, lease, or otherwise contract for vehicles, equipment, facilities, operators, or attendants;

(3) adopt rules and establish fees or charges for the furnishing of such ambulance service.

History: En. Sec. 2, Ch. 238, L. 1961; R.C.M. 1947, 69-3602.

7-34-104. Certain ambulance services unaffected. The provisions of this part shall in no way affect county, city, or town ambulance service in operation on March 14, 1961.

History: En. Sec. 3, Ch. 238, L. 1961; R.C.M. 1947, 69-3603.

Parts 2 through 20 reserved

Part 21

Hospital Districts

7-34-2101. Purpose of part. The purpose of this part is to authorize the establishment of public hospital districts which shall have power to supply hospital facilities and services to residents of such districts and, as herein authorized, to others.

History: En. Sec. 1, Ch. 155, L. 1955; amd. Sec. 1, Ch. 257, L. 1969; R.C.M. 1947, 16-4301(part).

(b) The county's part of the total expenses is financed by an appropriation from the general fund of the county after approval of a budget in the way provided for other county offices and departments under Title 7, chapter 6, part 23.

(c) Each participating city's part of the total expenses is financed by an appropriation from the general fund of the city after approval of a budget in the way provided for other city offices and departments under Title 7, chapter 6, part 42.

(d) All money shall be deposited with the county treasurer who shall disburse them as county funds.

(2) (a) In first- and second-class counties, the county commissioners and governing body of each participating city may mutually agree upon the division of the expenses.

(b) The county's part of the total expenses is financed by a special levy of not more than 5 mills on the taxable valuation of all property outside the incorporated limits of each participating city after approval of a budget in the way provided for other county offices and departments under Title 7, chapter 6, part 23. If the 5-mill levy is not sufficient to fund the county's share, the county commissioners may supplement it with an appropriation from the county general fund.

(c) Each participating city's part of the total expenses is financed by a special levy of not more than 5 mills on the taxable valuation of all property within the incorporated limits of the city after approval of a budget in the way provided for other city offices and departments under Title 7, chapter 6, part 42.

(d) All money shall be deposited with the county treasurer who shall disburse them as county funds.

(e) The special levies authorized by this subsection are in addition to all other levies authorized by law.

History: En. Sec. 85, Ch. 197, L. 1967; amd. Sec. 1, Ch. 351, L. 1974; amd. Sec. 21, Ch. 187, L. 1977; R.C.M. 1947, 69-4508(2)(c).

50-2-112. District board appropriations. (1) District boards are financed by appropriations from the general funds of each county in the district in proportion to the population in each county.

(2) First- and second-class cities which elect to be included in the district contribute to the county in which they are located in the way provided for city-county boards under 50-2-111.

(3) All funds shall be deposited with the county treasurer of one of the counties as agreed upon by the commissioners of the counties in the district. The county treasurer shall disburse the funds as county funds.

History: En. Sec. 85, Ch. 197, L. 1967; amd. Sec. 1, Ch. 351, L. 1974; amd. Sec. 21, Ch. 187, L. 1977; R.C.M. 1947, 69-4508(2)(d).

50-2-113. Contributions by school boards and other agencies authorized. School boards and other official and nonofficial agencies may contribute funds to a local board.

History: En. Sec. 85, Ch. 197, L. 1967; amd. Sec. 1, Ch. 351, L. 1974; amd. Sec. 21, Ch. 187, L. 1977; R.C.M. 1947, 69-4508(3).

50-2-114. Special mill levy. If the general fund of a city or county is not sufficient to meet the approved budget, a levy of not more than 1 mill

(c) additional members appointed by the county commissioners and governing body or bodies of the city or cities participating in the city-county board as mutually agreed upon who serve at the pleasure of the appointing commissioners or governing body.

(3) The board shall be composed of at least five persons. Terms of appointed members shall be staggered and shall be for 3 years each.

(4) By mutual agreement between the county commissioners and the governing body of the city, they shall establish the staggered order of terms and all regulations necessary to establish and maintain the board.

History: En. Sec. 83, Ch. 197, L. 1967; amd. Sec. 3, Ch. 216, L. 1969; R.C.M. 1947, 69-4506.

50-2-107. District boards of health. (1) By mutual agreement, two or more adjacent counties may unite to create a district board of health. First- and second-class cities located in those counties may elect to be included in the district.

(2) A district board of health consists of:

(a) one person appointed by the county commissioners of each county in the district who serves at the pleasure of the appointing commissioners;

(b) one person appointed by the governing body of each city that elects to be included in the district who serves at the pleasure of the appointing governing body;

(c) additional members appointed by the county commissioners of each county that participates in the district board as mutually agreed upon who serve at the pleasure of the appointing commissioners.

History: En. Sec. 84, Ch. 197, L. 1967; R.C.M. 1947, 69-4507.

50-2-108. Financing of local boards. Local boards are financed by general fund appropriations, special levy appropriations, state and federal funds available, and contributions from school boards and other official and nonofficial agencies.

History: En. Sec. 85, Ch. 197, L. 1967; amd. Sec. 1, Ch. 351, L. 1974; amd. Sec. 21, Ch. 187, L. 1977; R.C.M. 1947, 69-4508(1).

50-2-109. County board appropriations. County boards are financed by an appropriation from the general fund of the county after approval of a budget in the way provided for other county offices and departments under Title 7, chapter 6, part 23.

History: En. Sec. 85, Ch. 197, L. 1967; amd. Sec. 1, Ch. 351, L. 1974; amd. Sec. 21, Ch. 187, L. 1977; R.C.M. 1947, 69-4508(2)(a).

50-2-110. City board appropriations. City boards are financed by an appropriation from the general fund of the city after approval of a budget in the way provided for other city offices and departments under Title 7, chapter 6, part 42.

History: En. Sec. 85, Ch. 197, L. 1967; amd. Sec. 1, Ch. 351, L. 1974; amd. Sec. 21, Ch. 187, L. 1977; R.C.M. 1947, 69-4508(2)(b).

50-2-111. City-county board appropriations. If a city-county board is created, it is financed by one of the following methods:

(1) (a) The county commissioners and governing body of each participating city may mutually agree upon the division of expenses.

designate the amount thereof for each of the purposes, and each tax, when collected, constitutes a fund out of which the expenses incurred for the purpose for which the tax was levied shall be paid. The expenses incurred for any particular purpose shall be paid out of the fund provided therefor and not otherwise.

History: (1), (2)En. Sec. 1, Ch. 21, L. 1903; amd. Sec. 1, Ch. 106, L. 1907; Sec. 3344, Rev. C. 1907; re-en. Sec. 5201, R.C.M. 1921; amd. Sec. 2, Ch. 175, L. 1925; re-en. Sec. 5201, R.C.M. 1935; amd. Sec. 53, Ch. 100, L. 1973; amd. Sec. 89, Ch. 405, L. 1973; amd. Sec. 58, Ch. 566, L. 1977; Sec. 84-4713, R.C.M. 1947; (3)En. Sec. 2, Ch. 21, L. 1903; re-en. Sec. 3345, Rev. C. 1907; re-en. Sec. 5202, R.C.M. 1921; re-en. Sec. 5202, R.C.M. 1935; Sec. 84-4714, R.C.M. 1947; R.C.M. 1947, 84-4713, 84-4714; amd. Sec. 39, Ch. 252, L. 1979.

7-6-4439. Emergency provisions not affected. Nothing in 7-6-4431 through 7-6-4437 shall affect the emergency expenditures provided by law.

History: En. Sec. 7, Ch. 614, L. 1979.

7-6-4440 through 7-6-4450 reserved.

7-6-4451. All-purpose mill levy authorized. It is the purpose of 7-6-4451 through 7-6-4455 to authorize and empower the cities and towns of Montana, at their option, to make an all-purpose annual mill levy in lieu of the multiple levies now authorized by the statutes of Montana.

History: En. Sec. 1, Ch. 82, L. 1965; amd. Sec. 1, Ch. 226, L. 1969; amd. Sec. 1, Ch. 375, L. 1971; R.C.M. 1947, 84-4701.1(part).

7-6-4452. Maximum all-purpose mill levy. Except as provided elsewhere, the cities and towns of the state of Montana may make an all-purpose annual levy upon the taxable value of all the property in the cities and towns subject to taxation for municipal purposes in lieu of the multiple levies now authorized by statute. The total of the all-purpose levy may not exceed 65 mills on the dollar.

History: En. Sec. 2, Ch. 82, L. 1965; amd. Sec. 2, Ch. 226, L. 1969; amd. Sec. 2, Ch. 226, L. 1969; amd. Sec. 2, Ch. 375, L. 1971; amd. Sec. 57, Ch. 566, L. 1977; R.C.M. 1947, 84-4701.2(part).

7-6-4453. Certain special mill levies also available. (1) The all-purpose mill levy shall not and may not include the levies imposed for bonded indebtedness, to pay judgments, or for special improvement district revolving funds of municipalities, which levies may be made in addition to the all-purpose levy, as provided in subsection (2). Sections 7-6-4451 through 7-6-4455 shall not be construed as repealing those statutes providing for multiple separate levies.

(2) Extraordinary levies otherwise authorized to pay for bonded indebtedness, judgments, or special improvement district revolving funds may be made by such municipalities in addition to such all-purpose levy provided in 7-6-4451 through 7-6-4455.

History: Ap. p. Sec. 1, Ch. 82, L. 1965; amd. Sec. 1, Ch. 226, L. 1969; amd. Sec. 1, Ch. 375, L. 1971; Sec. 84-4701.1, R.C.M. 1947; Ap. p. 84-4701.6 by Sec. 1, Ch. 145, L. 1967; amd. Sec. 5, Ch. 375, L. 1971; Sec. 84-4701.6, R.C.M. 1947; Ap. p. Sec. 2, Ch. 82, L. 1965; amd. Sec. 2, Ch. 226, L. 1969; amd. Sec. 2, Ch. 375, L. 1971; amd. Sec. 57, Ch. 566, L. 1977; Sec. 84-4701.2, R.C.M. 1947; R.C.M. 1947, 84-4701.1(part), 84-4701.2(part), 84-4701.6.

7-6-4454. Certification of all-purpose levy to county officers. In the event that it is necessary to certify such a municipal levy to county officers for collection, the same shall be certified as an all-purpose levy.

History: En. Sec. 5, Ch. 82, L. 1965; amd. Sec. 4, Ch. 375, L. 1971; R.C.M. 1947, 84-4701.5.

Part 1

Development of Program

50-6-101. Legislative purpose. The public welfare requires the providing of assistance and encouragement for the development of a comprehensive emergency medical services program for Montanans who each year are dying and suffering permanent disabilities needlessly because of inadequate emergency medical services. The repeated loss of persons who die unnecessarily because necessary life-support personnel and equipment are not available to victims of accidents and sudden illness is a tragedy that can and must be eliminated. The development of an emergency medical services program is in the interest of the social well-being and health and safety of the state and all its people.

History: En. 69-7001 by Sec. 1, Ch. 311, L. 1974; R.C.M. 1947, 69-7001.

50-6-102. Department to establish and administer program. The department of health and environmental sciences shall establish and administer an emergency medical services program.

History: En. 69-7002 by Sec. 2, Ch. 311, L. 1974; amd. Sec. 38, Ch. 213, L. 1975; R.C.M. 1947, 69-7002(part).

50-6-103. Powers of department. (1) The department of health and environmental sciences is authorized to confer and cooperate with any and all other persons, organizations, and governmental agencies that have an interest in emergency medical services problems and needs.

(2) The department is authorized to accept, receive, expend, and administer any and all funds which are now available or which may be donated, granted, or appropriated to the department.

History: En. 69-7002 by Sec. 2, Ch. 311, L. 1974; amd. Sec. 38, Ch. 213, L. 1975; R.C.M. 1947, 69-7002(part).

50-6-104. Interdepartmental cooperation required. The department of health and environmental sciences, the department of community affairs, highway safety division, and other interested departments or divisions shall develop in writing a mutually agreeable plan of cooperation so that governmental effort will not be duplicated and governmental resources will be applied on a reasonable priority basis.

History: En. 69-7002 by Sec. 2, Ch. 311, L. 1974; amd. Sec. 38, Ch. 213, L. 1975; R.C.M. 1947, 69-7002(part).

Part 2

Emergency Medical Technicians

50-6-201. Legislative findings. The legislature finds and declares that prompt and efficient emergency medical care of the sick and injured at

related to ambulance equipment and training which exceed these requirements.

History: En. Sec. 6, Ch. 387, L. 1971; amd. Sec. 107, Ch. 349, L. 1974; R.C.M. 1947, 69-3609(4).

50-6-306. License required. (1) Every person conducting or operating an ambulance service shall procure a license issued by the department. A separate license shall be required for each establishment.

(2) Applications for a license shall be made in writing to the department on forms specified by the department.

(3) Licenses shall be granted as a matter of right unless conditions exist as specified by this part which are grounds for a cancellation or denial of a license.

(4) The applicant may apply for a hearing and judicial review as specified by this part upon being denied a license or upon cancellation.

(5) Each license shall expire on December 31 following its date of issue unless canceled for cause. Renewal may be obtained by paying the required annual license fee.

(6) The license shall not be transferable or be applicable to any premises other than that for which originally issued.

History: En. Secs. 3, 4, Ch. 387, L. 1971; R.C.M. 1947, 69-3606, 69-3607(2).

50-6-307. License fee. (1) There shall be paid to the department, with each application for a license or for renewal of a license, an annual license fee of $5.

(2) The department shall deposit fees with the state treasurer to the credit of the state general fund.

(3) Payment of the license fee stipulated in this part shall be accepted in lieu of any and all existing state fees and charges for like purposes or intent which may be existent prior to the adoption of this part.

History: En. Secs. 4, 10, Ch. 387, L. 1971; R.C.M. 1947, 69-3607(1), 69-3613.

50-6-308. Cancellation of license. The department may cancel a license if it finds that the licensee has violated provisions of or rules adopted under this part and the licensee has failed or refused to remedy or correct the violation.

History: En. Sec. 5, Ch. 387, L. 1971; amd. Sec. 12, Ch. 349, L. 1974; R.C.M. 1947, 69-3608(part).

50-6-309. Submission of plan of correction as bar to cancellation. Submission to the department of an acceptable plan of correction within 10 days after receipt from the department of written notice of violation and execution of an acceptable plan within the time prescribed in the written notice of approval of the plan by the department is a bar to prosecution for violation.

History: En. Sec. 5, Ch. 387, L. 1971; amd. Sec. 12, Ch. 349, L. 1974; R.C.M. 1947, 69-3608(part).

50-6-310. Notice and hearing required. (1) The department may not deny or cancel a license without:

(a) delivery to the applicant or licensee of a written statement of the grounds for the denial or cancellation or the charge involved;

may be made on the taxable valuation of all property in the city or county in addition to all other levies authorized by law. This section does not apply when the board has been financed under 50-2-111(2).

History: En. Sec. 85, Ch. 197, L. 1967; amd. Sec. 1, Ch. 351, L. 1974; amd. Sec. 21, Ch. 187, L. 1977; R.C.M. 1947, 69-4508(4).

50-2-115. Legal adviser to local boards. The county attorney shall serve as legal adviser to local boards as established by 50-2-104 and 50-2-106. The county attorney shall represent the local board in those matters relating to the functions, powers, and duties of local boards.

History: En. 69-4508.1 by Sec. 1, Ch. 273, L. 1975; R.C.M. 1947, 69-4508.1.

50-2-116. Powers and duties of local boards. (1) Local boards shall:

(a) appoint a local health officer who is a physician or a person with a master's degree in public health or equivalent and appropriate experience as determined by the department and fix his salary;

(b) elect a chairman and other necessary officers;

(c) employ necessary qualified staff;

(d) adopt bylaws to govern meetings;

(e) hold regular meetings quarterly and hold special meetings as necessary;

(f) supervise destruction and removal of all sources of filth which cause disease;

(g) guard against the introduction of communicable disease;

(h) supervise inspections of public establishments for sanitary conditions.

(2) Local boards may:

(a) quarantine persons who have communicable diseases;

(b) require isolation of persons or things which are infected with communicable diseases;

(c) furnish treatment for persons who have communicable diseases;

(d) prohibit the use of places which are infected with communicable diseases;

(e) require and provide means for disinfecting places which are infected with communicable diseases;

(f) accept and spend funds received from a federal agency, the state, a school district, or other persons;

(g) contract with another local board for all or a part of local health services;

(h) reimburse local health officers for necessary expenses incurred in official duties;

(i) abate nuisances affecting public health and safety or bring action necessary to restrain the violation of public health laws or rules;

(j) adopt necessary regulations and fees for the control and disposal of sewage from private and public buildings not currently connected to any municipal system (fees shall be deposited with the county treasurer);

(k) adopt rules which do not conflict with rules adopted by the department:

(i) for the control of communicable diseases;

(ii) for the removal of filth which might cause disease or adversely affect public health;

(c) perform cardiopulmonary resuscitation and defibrillation in a ulseless, nonbreathing patient; and

(d) such other acts as the board may allow by rule.

(2) When an emergency medical technician—advanced has voice contact ;ith a physician and upon the physician's order or is functioning under for-nally adopted written standing orders of a local hospital medical staff, the ollowing acts may be performed based upon such direct or indirect order:

(a) administer intravenous saline or glucose solutions;

(b) perform gastric or tracheal suction by intubation;

(c) administer parenteral injections of drugs approved by the board; and

(d) such other acts as the board may allow by rule.

History: En. 69-7006, 69-7007 by Secs. 4, 5, Ch. 84, L. 1975; R.C.M. 1947, 69-7006, 69-7007.

50-6-206. Consent. No emergency medical technician may be subject to civil liability for failure to obtain consent in performing acts as authorized herein to any individual regardless of age where the patient is unable to give consent and there is no other person present legally authorized to consent, provided that such acts are in good faith and without knowledge of facts negating consent.

History: En. 69-7009 by Sec. 7, Ch. 84, L. 1975; R.C.M. 1947, 69-7009.

50-6-207. Construction. Nothing in this part shall be construed to detract from the powers granted to the department of health and environmental sciences to regulate ambulance service as provided for in part 3 of this chapter.

History: En. 69-7010 by Sec. 8, Ch. 84, L. 1975; R.C.M. 1947, 69-7010.

Part 3

Ambulance Service Licensing

50-6-301. Findings and purposes. The public welfare requires the establishment of minimum uniform standards for the operation of ambulance services, as defined in 50-6-302, and the control, inspection, and regulation of persons engaged therein in order to prevent or eliminate improper care that may endanger the health of the public. The regulation of establishments providing such service is in the interest of social well-being and the health and safety of the state and all its people.

History: En. Sec. 1, Ch. 387, L. 1971; R.C.M. 1947, 69-3604.

50-6-302. Definitions. Unless the context requires otherwise, in this part the following definitions apply:

(1) "Ambulance" means a privately or publicly owned motor vehicle that is especially designed, constructed, and equipped which is maintained and used for the transportation of patients, including dual purpose police patrol cars and funeral coaches or hearses which otherwise comply with this part, but does not include a motor vehicle owned by or operated under the direct control of the United States or this state.

(2) "Ambulance service" means a person who operates an ambulance.

(3) "Attendant" means a trained or otherwise qualified individual responsible for the operation of an ambulance and the care of the patients whether or not the attendant also serves as driver.

(4) "Attendant-driver" means a person who is qualified as an attendant and a driver.

(5) "Board" means the board of health and environmental sciences, provided for in 2-15-2104.

(6) "Department" means the department of health and environmental sciences, provided for in Title 2, chapter 15, part 21.

(7) "Driver" means an individual who drives an ambulance.

(8) "Dual purpose police patrol car" means a vehicle operated by a police department which is equipped as an ambulance, even though it is also used for patrol or other police purposes.

(9) "Patient" means an individual who is sick, injured, wounded, or otherwise incapacitated or helpless. The term does not include a person who is nonambulatory and who needs transportation assistance solely because that person is confined to a wheelchair as his usual means of mobility.

(10) "Person" means an individual, firm, partnership, association, corporation, company, group of individuals acting together for a common purpose, or organization of any kind, including a governmental agency other than the United States or this state.

History: En. Sec. 2, Ch. 387, L. 1971; amd. Sec. 11, Ch. 349, L. 1974; amd. Sec. 1, Ch. 86, L. 1977; R.C.M. 1947, 69-3605.

50-6-303. Rules. (1) The department shall prescribe and enforce rules which are necessary to carry out the provisions of this part.

(2) These rules shall relate to ambulance equipment, training, operations (records), personnel, cleanliness, and insurance.

(3) No rules shall be effective until a public hearing has been held for review of the rules.

(4) Notice of the public hearing shall be sent by ordinary mail at least 30 days before the hearing to all Montana licensed operators along with a copy of the proposed rules.

History: En. Sec. 6, Ch. 387, L. 1971; amd. Sec. 107, Ch. 349, L. 1974; R.C.M. 1947, 69-3609(1), (2).

50-6-304. Cooperative agreements. The department may enter into cooperative agreements with any of the state agencies or political subdivisions for the purpose of carrying out the provisions of this part or any part thereof.

History: En. Sec. 6, Ch. 387, L. 1971; amd. Sec. 107, Ch. 349, L. 1974; R.C.M. 1947, 69-3609(3).

50-6-305. Minimum equipment requirements. (1) Pursuant to the provisions of this part, required equipment in an ambulance which is maintained and regularly used for the transportation of patients shall consist of the minimal equipment for ambulances as adopted by the American college of surgeons, March, 1967, and required training shall be set at a level of advanced American red cross first aid or its equivalent.

(2) Nothing in this section shall preclude the use of any vehicle for the transportation of the injured in instances of emergency, need, or disaster situations, and the department shall not prescribe and enforce any rules

FEB 2 0 1981

VISITORS' REGISTER

HOUSE Human Services COMMITTEE

BILL 1911 Date 2-20-81

SPONSOR Mr. Scott

NAME	RESIDENCE	REPRESENTING	SUP-PORT	OP-POSE

IF YOU CARE TO WRITE COMMENTS, ASK SECRETARY FOR LONGER FORM.

PLEASE LEAVE PREPARED STATEMENT WITH SECRETARY.

Form CS-33
1-81

WITNESS STATEMENT

NAME Jim Johnson BILL No. 764

ADDRESS Box 755 Glendive MT DATE 2-26-81

WHOM DO YOU REPRESENT KR Ag

SUPPORT yes OPPOSE _____ AMEND _____

PLEASE LEAVE PREPARED STATEMENT WITH SECRETARY.

Comments:

FORM CS-34
1-81

WITNESS STATEMENT

NAME Wayne Dumont BILL No. HB 704

ADDRESS 418 Carter, Blue Ridge DATE 2-20-81

WHOM DO YOU REPRESENT KN - Self

SUPPORT X OPPOSE AMEND

PLEASE LEAVE PREPARED STATEMENT WITH SECRETARY.

Comments:

FORM CS-34
1-81

WITNESS STATEMENT

NAME John A. Adams BILL No. 760

ADDRESS Box 755 Coolidge, AZ. DATE 2-16-81

WHOM DO YOU REPRESENT Self

SUPPORT / OPPOSE AMEND

PLEASE LEAVE PREPARED STATEMENT WITH SECRETARY.

Comments:

FORM CS-34
1-81

WITNESS STATEMENT

NAME Barbara Simonsen BILL No. 764

ADDRESS 1001 Gilbert Deer Lodge DATE 2/20/81

WHOM DO YOU REPRESENT Self

SUPPORT ✓ OPPOSE _____ AMEND _____

PLEASE LEAVE PREPARED STATEMENT WITH SECRETARY.

Comments:

FORM CS-34
1-81

WITNESS STATEMENT

NAME Dennis Pond BILL No. 764

ADDRESS Box 104 DATE 2/20/81

WHOM DO YOU REPRESENT Self

SUPPORT _____ OPPOSE X AMEND _____

PLEASE LEAVE PREPARED STATEMENT WITH SECRETARY.

Comments:

FORM CS-34
1-81

WITNESS STATEMENT

NAME W. L. Linden BILL No. 769

ADDRESS 314 N Radnor DATE 2/19

WHOM DO YOU REPRESENT Linden Ambulance

SUPPORT _____ OPPOSE X AMEND _____

PLEASE LEAVE PREPARED STATEMENT WITH SECRETARY.

Comments:

FORM CS-34
1-81

WITNESS STATEMENT

NAME John Baines BILL No. 764

ADDRESS _____ DATE 2/19/81

WHOM DO YOU REPRESENT Self

SUPPORT _____ OPPOSE X AMEND _____

PLEASE LEAVE PREPARED STATEMENT WITH SECRETARY.

Comments:

FORM CS-34
1-81

WITNESS STATEMENT

NAME Jack Thomas BILL No. 764

ADDRESS 2900 Gladstone Ave Bottc DATE 2/20/81

WHOM DO YOU REPRESENT Floral Park VFD

SUPPORT _____ OPPOSE / AMEND _____

PLEASE LEAVE PREPARED STATEMENT WITH SECRETARY.

Comments:

FORM CS-34
1-81

WITNESS STATEMENT

NAME William E. Murray BILL No. 769

ADDRESS Rm 248 Cosco Bldg DATE 2/20/81

WHOM DO YOU REPRESENT Cascade County EMS

SUPPORT _____ OPPOSE X AMEND _____

PLEASE LEAVE PREPARED STATEMENT WITH SECRETARY.

Comments:

FORM CS-34
1-81

WITNESS STATEMENT

NAME Pamela Tinsman BILL No. 764

ADDRESS Box 243, Richland DATE 2-20-81

WHOM DO YOU REPRESENT Self

SUPPORT _____ OPPOSE X AMEND _____

PLEASE LEAVE PREPARED STATEMENT WITH SECRETARY.

Comments:

FORM CS-34
1-81

WITNESS STATEMENT

NAME Mike Anderson BILL No. 764

ADDRESS Bellingham DATE 2-20-91

WHOM DO YOU REPRESENT Seattle Audubon

SUPPORT _____ OPPOSE X AMEND _____

PLEASE LEAVE PREPARED STATEMENT WITH SECRETARY.

Comments:

FORM CS-34
1-81

WITNESS STATEMENT

NAME Donna Small BILL No. 764

ADDRESS 1208 Caldwell Ln. Big. MT. 59102 DATE 2-26-91

WHOM DO YOU REPRESENT Mont. Nurses Assoc.

SUPPORT X OPPOSE AMEND

PLEASE LEAVE PREPARED STATEMENT WITH SECRETARY.

Comments:

FORM CS-34
1-81

WITNESS STATEMENT

NAME Barbara J. Lewis BILL No. 797

ADDRESS 613 Kirk Dr. DATE 2/26/81

WHOM DO YOU REPRESENT West Ill. Pharmaceutical Assoc.

SUPPORT " OPPOSE _____ AMEND "

PLEASE LEAVE PREPARED STATEMENT WITH SECRETARY.

Comments:

Limit testimony provided

FORM CS-34
1-81

VISITORS' REGISTER

HOUSE [illegible] COMMITTEE

BILL [illegible] Date 2-20-81

SPONSOR [illegible]

NAME	RESIDENCE	REPRESENTING	SUPPORT	OPPOSE
Geraldine McKnight	Helena	Dept. of Health & ES		✓
~~[illegible]~~	~~[illegible]~~	~~[illegible]~~		✓
Ken Kurtledge	Helena	Montana Hospital Assn	✓	
Grant M. Winn	Missoula	Missoula County Hosp	✓	

IF YOU CARE TO WRITE COMMENTS, ASK SECRETARY FOR LONGER FORM.

PLEASE LEAVE PREPARED STATEMENT WITH SECRETARY.

Form CS-33
1-81

MHA amend to HB 734

XIV

Montana Hospital Association

(406) 442-1911 · P. O. BOX 5119 · HELENA, MONTANA 59601

AMENDMENTS TO H.B. 734

I move to amend HB 734 by:

In title: line 5, strike words ~~HEALTH-CARE-FACILITIES~~ and substitute the word HOSPITALS

Page 8, line 25 - Strike the words ~~health-care-facility~~ and substitute the word hospital

Page 9, line 1 - Insert the words "including the recommendation for future compliance statement" following the word "evidence" and before the word "to".

Page 9, line 12 - New Section:

All written evidence submitted by the hospital to the State Department of Health and Environmental Sciences shall be confidential and not released to any person without a prior written release signed by the Chief Executive Officer of the hospital.

Montana Hospital Association

(406) 442-1911 · P. O. BOX 5119 · HELENA, MONTANA 59601

TESTIMONY IN SUPPORT OF HOUSE BILL 734

For the record, I am William Leary, president of the Montana Hospital Association, appearing here today on behalf of Montana hospitals to urge your support of H.B. 734 and to present some minor amendments which were requested by officials of the State Department of Health and with which we concur.

The amendments are attached to my testimony.

When a Montana hospital receives its notification of accreditation by the Joint Commission on Accreditation of Hospitals, it means that facility has voluntarily sought to be measured against optimal achievable standards for quality of care and services, standards that apply to the performance of each function in the overall operation of the facility. The fact that the hospital has achieved its accreditation means the hospital has been found to be in substantial compliance with the standards and is making an effort to provide even better care and services. Accreditation can thus document accountability of a facility to those who support it and to those it serves.

Accreditation is much more than an evaluation or a survey, however. Elements of consultation and education are found throughout the accreditation process. The pre-survey activities such as self-evaluation are distinctly educational. The summation conference in which the surveyors meet with representatives of the facility to discuss on-site survey findings and to make suggestions for improvement provides valuable consultation. The complete report of survey findings that accompanies each accreditation decision is also a consultative service that details the facility's strengths and weaknesses and makes recommendations for correcting deficiencies and raising the level of performance.

The meaning of accreditation is sometimes misunderstood. A common misconception is that the Joint Commission is a regulatory agency of the government. This is not the case. The Joint Commission is a private, not-for-profit corporation. Accreditation by the JCAH is a voluntary process that uses optimal and yet achievable criteria as a basis for evaluating quality of performance. It encompasses more than and should be distinguished from

certification or licensure, which are regulatory governmental determinations of a facility's ability to operate, most often based on minimum requirements.

JCAH accreditation, however, is often used as a benchmark of quality by some regulatory agencies in granting certification and licensure. That is essentially what we are attempting to do through the introduction of House Bill 734. We want to provide recognition by the state of Montana and more specifically the State Department of Health whereby any hospital which is accredited and remains accredited will be deemed licensed by the State Department of Health as long as the hospital furnishes written evidence including the JCAH recommendations for future compliance to the State Department of Health. It is the contention of the Montana Hospital Association and its members that regardless of whether accreditation is granted for one year or two years, the hospital, its medical staff, its governing board and other members of the administrative departmentalized team have worked hard and devoted many hours to the accreditation process and to guarantee to the public that their hospital is providing the highest quality of services.

I have attached to my testimony the fact sheet on status of JCAH hospitals in Montana and other supporting information. I encourage you to read these attachments prior to your decision on House Bill 734 and I sincerely hope your decision will be a unanimous DO PASS.

Thank you.

Montana Hospital Association

(406) 442-1911 · P. O. BOX 5119 · HELENA, MONTANA 59601

FACT SHEET

STATUS OF JOINT COMMISSION ON ACCREDITATION OF HOSPITALS IN MONTANA

There are currently 22 nonfederal Montana hospitals accredited by the Joint Commission on Accreditation of Hospitals (JCAH) ranging in size from 25-282 beds. All of the 22 hospitals are licensed by the State of Montana and are Medicare certified. (see attached list)

The total number of licensed and accredited beds in the 22 hospitals is 2,489. The average size of the accredited facility is 113 beds.

Sixteen hospitals have a two-year accreditation, representing 73%; 6 hospitals have a one-year accreditation, representing 27%. This compares with the national data for JCAH which shows that as of November 30, 1980 there were:

1,634 hospitals having a two-year accreditation or 71%

651 hospitals having a one-year accreditation or 28%

28 hospitals failed to be accredited as they did not meet the standards - 1%

Total of 2,313 hospitals surveyed.

The other 39 Montana general hospitals ranging in size from 6-104 beds are non-accredited but are all licensed and Medicare certified. The total number of licensed beds in the 39 hospitals is 954. The average size of the non-accredited hospital is 25 beds.

In addition to the hospitals which are subjected to licensure in Montana, there are 5 federal hospitals which in accordance with federal and state law are not required to have state licensure but are accredited by the JCAH. These 5 federal institutions have a total of 366 beds and all but one is accredited for the two-year period. The other has a one year accreditation.

Refer to the status sheet attached for a listing of Montana hospitals that are accredited by JCAH, the date of survey and the result of their accreditation status.

Accredited hospitals subject to licensure by Montana State Department of Health

City	Name	Beds	Surveyed	Result
Anaconda	Community	60	July 1979	2 year
Billings	Billings Deaconess	197	Sept. 11, 1980	2 year
Billings	St. Vincent	225	Aug. 15, 1980	2 year
Butte	St. James Community	180	Sept. 8, 1980	1 year
Butte	Silver Bow General	140	October 1978	2 year
Conrad	Pondera Medical Center	50	Sept. 4, 1980	1 year
Deer Lodge	Powell County Memorial	35	Aug. 8, 1980	1 year
Glasgow	Frances Mahon Deaconess Chemical Dependency Center	48 51	July 1979	2 year
Glendive	Glendive Community	46	July 1979	2 year
Great Falls	Columbus	198	July 17, 1980	2 year
Great Falls	Montana Deaconess Medical Center	282	July 1979	2 year
Havre	Northern Montana	120	July 22, 1980	2 year
Helena	St. Peter's Community	120	July 30, 1980	2 year
Kalispell	Kalispell Regional	91	July 11, 1980	2 year
Lewistown	Central Montana	47	Sept. 15, 1980	2 year
Libby	St. John's Lutheran	34	Sept. 2, 1980	1 year
Miles City	Holy Rosary	120	Aug. 21, 1980	1 year
Missoula	Community	115	July 1979	2 year
Missoula	General	57	Aug. 6, 1980	2 year
Missoula	St. Patrick	217	December 1979	2 year
Polson	St. Joseph	40	Aug. 28, 1980	2 year
Ronan	St. Luke's Community	25	Aug. 27, 1980	1 year

ACCREDITED HOSPITALS NOT SUBJECT TO LICENSURE IN MONTANA - FEDERAL INSTITUTIONS

City	Name	Beds	Surveyed	Result
Fort Harrison	Veterans Administration	160	Aug. 1, 1980	2 year
Miles City	Veterans Administration	120	Aug. 20, 1980	2 year
Crow Agency	USPHS Indian Hospital	34	Aug. 19, 1980	2 year
Browning	USPHS Indian Hospital	34	July 15, 1980	1 year
Harlem	USPHS Indian Hospital	18	July 24, 1980	2 year

TESTIMONY IN SUPPORT OF HOUSE BILL 734

Mr. Chairman, Members of the Committee, I am Joanne Dodd, registered nurse, vice president of nursing service at Billings Deaconess Hospital, and appear today in support of the adoption of House Bill 734.

The accreditation process as conducted by the Joint Commission on Accreditation of Hospitals is an ongoing, year-round function with its basis centering on strong education and coordination of all the various units within the hospital.

I am available to answer questions regarding the accreditation survey of nursing services, specifically to answer the goal that there shall be an organized nursing department/service that takes all reasonable steps to provide optimal, achievable quality of nursing care and to maintain optimal professional conduct and practices of its members.

I urge you to pass House Bill 734. Thank you.

Department of Health and Environmental Sciences
STATE OF MONTANA HELENA, MONTANA 59620

John J. Drynan, M.D.
Director

February 20, 1981
PUBLIC HEALTH COMMITTEE

HOUSE BILL 734

Mr. Chairman and members of the committee, my name is Jacqueline McKnight and I am Chief, Health Facilities Licensing and Certification Bureau, Department of Health and Environmental Sciences.

House Bill 734 grants state licensure of health care facilities by virtue of accreditation by the Joint Commission on Accreditation of Hospitals.

The Department of Health and Environmental Sciences has the following serious concerns with the bill:

1. Issuance of a license by the State to a health care facility indicates to the public that the facility is state inspected, minimum standards are met, staff is qualified and that the operation will not result in undue hazards to patients or residents. Neither I nor the Department wish to issue a license based on a survey conducted by other than the department's authorized agents.

2. Only J.C.A.H. accredited hospitals have deemed status for Medicare Certification under Public Law 89-97. All other providers of health services wishing to be certified under Title 18, Medicare, and Title 19, Medicaid, would still be required to undergo survey by the state under the appropriate Federal Conditions of Participation. State licensure and Federal surveys are conducted simultaneously.

3. J.C.A.H. survey eligibility criteria states hospitals "...must have a valid current license to operate." J.C.A.H. obviously places value on state licensure surveys, or they would not have the requirement.

4. Before the Joint Commission on Accreditation does surveys in the State of Montana, they request a list of the deficiencies found by the state survey agency to be used in their accreditation survey process.

5. State license inspections are made annually by Montana Health Care Professionals who have knowledge of all health care providers and resources in the state. Familiarity gained from the survey process enables them to give consultation to all providers as requested, including J.C.A.H. accredited hospitals.

6. There are 22 J.C.A.H. accredited hospitals in the state. Nine provide hospital services only. The remaining 13 provide other services that must be surveyed by the state for Title 18 and/or 19 Certification purposes. Seven have skilled nursing facilities, four have End Stage Renal Dialysis Services and four have Home Health Agencies.

7. House Bill 734 would not exempt J.C.A.H. hospitals from the Medicare validation survey program mandated by Congress.

The Department of Health and Environmental Sciences believes that the passage of this bill would not serve the best interests of J.C.A.H. accredited hospitals or Montana citizens.

If you consider this bill favorably, the Department must request the following change and amendments.

AMENDMENT

Page 1
The title of the bill should be changed to:

"AN ACT TO WAIVE STATE LICENSURE INSPECTION FOR HOSPITALS THAT ARE ACCREDITED FOR TWO YEARS BY THE JOINT COMMISSION ON ACCREDITATION OF HOSPITALS."

Reason: Hospitals, under Public Law 89-97 have deemed status for Title XVIII, Medicare Certification. No other health care providers accredited by J.C.A.H. have deemed status and are therefore required to have state survey for Medicare and Medicaid Certification.

Reason: Only hospitals accredited for two years should be considered for waiver of state licensure inspections. J.C.A.H. grants accreditation for one or two years. The granting of accreditation, they state, means that the hospital is in substantial compliance with its standards but the "one-year accreditation signifies that the nature of the survey findings necessitates an on-site survey within one year to assess progress in correction of deficiencies," in effect it is probationary accreditation.

Page 4
Lines 17 and 19. Strike "health care facilities"
Insert "hospitals"

Page 8
Line 25. Strike "written evidence"
Insert "a copy of the accrediting letter and complete J.C.A.H. survey findings."

Reason: If the State is to issue a license on the basis of a J.C.A.H. survey, the state agency must have documentation in the form of the accrediting letter and a copy of the J.C.A.H. survey findings to support issuing a license.

End
Line 6. Strike "health care facility"
Insert "hospital"

JMcK/lh

J.C.A.H. Hospitals

Hospitals	Other Provider Services
1. Community Hospital of Anaconda, Anaconda	Skilled Nursing Facility
2. Billings Deaconess Hospital, Billings	End Stage Renal Dialysis
3. St. Vincent's Hospital, Billings	---
4. St. James Community Hospital, Butte	---
5. Silver Bow General Hospital, Butte	Skilled Nursing Facility
6. Pondera Medical Center, Conrad	---
7. Powell County Memorial Hospital, Deer Lodge	---
8. Frances Mahon Deaconess Hospital, Glasgow	Skilled Nursing Facility
9. Glendive Community Hospital, Glendive	Skilled Nursing Facility
10. Columbus Hospital, Great Falls	Home Health Agency and End Stage Renal Dialysis
11. Montana Deaconess Medical Center, Great Falls	Home Health Agency and Skilled Nursing Facility
12. Northern Montana Hospital, Havre	---
13. St. Peter's Community Hospital, Helena	End Stage Renal Dialysis
14. Kalispell Regional Hospital, Kalispell	---
15. Central Montana Hospital, Lewistown	Skilled Nursing Facility
16. St. John's Lutheran Hospital, Libby	---
17. Holy Rosary Hospital, Miles City	Home Health Agency
18. Missoula Community Hospital, Missoula	---
19. Missoula General Hospital, Missoula	---
20. St. Patrick Hospital, Missoula	End Stage Renal Dialysis
21. St. Joseph Hospital, Polson	Home Health Agency
22. St. Luke Community Hospital, Ronan	Skilled Nursing Facility

JMcK/lh

VISITORS' REGISTER

HOUSE Human Services COMMITTEE

BILL SB 37 Date 1-22-81

SPONSOR Christiaens

NAME	RESIDENCE	REPRESENTING	SUPPORT	OPPOSE
Jacqueline McKnight	Helena	Dept of Health & ES		✓
Ken Rutledge	Helena	Mon Tana Hosp Assn	✓	
Grant M. Winn	Missoula	Msla Comm Hosp	✓	

IF YOU CARE TO WRITE COMMENTS, ASK SECRETARY FOR LONGER FORM.

PLEASE LEAVE PREPARED STATEMENT WITH SECRETARY.

Form CS-33
1-81

Montana Hospital Association

(406) 442-1911 · P. O. BOX 5119 · HELENA, MONTANA 59601

AMENDMENT TO HOUSE BILL 735

I move to amend H.B. 735 by:

Page 9, line 3:

New Section: Section 3. This Act ~~shall apply~~ applies only to those clinical laboratories operated by a licensed Montana hospital.

Current Section 3 would be renumbered as Section 4.

Montana Hospital Association

(406) 442-1911 · P. O. BOX 5119 · HELENA, MONTANA 59601

TESTIMONY IN SUPPORT OF HOUSE BILL 735

For the record, I am William Leary, president of the Montana Hospital Association, appearing today in support of the passage of House Bill 735.

This bill is very similar to House Bill 734, however there are some distinct differences in that while the Joint Commission on Accreditation of Hospitals does accredit an entire hospital, the Joint Commission does rely upon the outstanding high quality accreditation review conducted on clinical laboratories by the College of American Pathologists as further evidence that the clinical laboratory is meeting extremely high standards and has adopted high quality control systems to measure the pathology and medical laboratory services.

Thus, if a clinical laboratory operated by a hospital has been previously accredited and maintains its accreditation through the College of American Pathologists, the Joint Commission on Accreditation of Hospitals will accept that in lieu of its own survey by JCAH surveyors. This avoids duplication of effort and also does provide some cost savings to the hospital.

We feel it is proper, therefore, that those clinical laboratories which have been accredited by the College of American Pathologists be exempt from inspection by the State Department of Health during the period of their accreditation.

Officials from the State Department of Health indicated some confusion over this bill and had interpreted it to mean that they would have to go out and license all clinical laboratories, including those operated within a physician's office and this was not the intent of this legislation.

I am, therefore, offering an amendment to House Bill 735 which will make it clear that this Act shall apply only to those clinical laboratories operated by a licensed Montana hospital. That proposed amendment is attached to my testimony.

I do urge your consideration and a DO PASS for House Bill 735.

Thank you.

Department of Health and Environmental Sciences
STATE OF MONTANA HELENA, MONTANA 59620

John J. Drynan, M.D.
Director

February 20, 1981
PUBLIC HEALTH COMMITTEE

HOUSE BILL 735

Mr. Chairman and members of the committee, my name is Jacqueline McKnight and I am Chief, Health Facilities Licensing and Certification Bureau, Department of Health and Environmental Sciences. The Department of Health and Environmental Sciences opposes this bill on the grounds that:

1. The bill mandates state licensure of clinical laboratories which are not now required to be licensed and then waives those laboratories that are accredited by the College of American Pathologists.

2. Laboratories in hospitals are covered as a service by the hospital license and should not be licensed separately.

3. There are ten independent laboratories, all requesting certification under Title XVIII, Medicare. These laboratories will continue to be required to be surveyed by the State under the Federal Conditions of Participation for clinical laboratories because College of American Pathologists accreditation does not have deemed status under Public Law 89-97.

4. We estimate there are 500 clinical laboratories in doctors' offices that would require licensure under this bill.

Because the passage of the bill will not accomplish the stated purpose of the sponsor, the Department of Health and Environmental Sciences urges you to vote DO NOT PASS on House Bill 735.

JMcK/lh

FEB 20 1981

VISITORS' REGISTER

HOUSE Human Services COMMITTEE

BILL 784 - HJR-39 Date 2-20-81

SPONSOR Reeve -

NAME	RESIDENCE	REPRESENTING	SUPPORT	OPPOSE
Manuel Machado	Missoula	Hispanics	✓	

IF YOU CARE TO WRITE COMMENTS, ASK SECRETARY FOR LONGER FORM.

PLEASE LEAVE PREPARED STATEMENT WITH SECRETARY.

Form CS-33
1-81

NAME Carl J. Donovan BILL No. H.B. 784

ADDRESS Box 1201 Gt. Falls, MT. 59403 DATE 2/20/81

WHOM DO YOU REPRESENT Montana's Power to the People M.P.P.

SUPPORT X OPPOSE AMEND

PLEASE LEAVE PREPARED STATEMENT WITH SECRETARY.

Comments:

M.P.P. is in favor of H.B 784.

We feel there is an increasing need of awareness of Montana's Hispanic populations.

A Liaison within the S.R.S. is a step forward for the Hispanic people.

Therfore we urge a do pass recommendation for this bill.

FORM CS-34
1-81

STATEMENT OF INTENT HB 755

A statement of intent is required for this bill because it delegates rulemaking authority to the Department of Social and Rehabilitation Services in Section 5, in part for the purpose of adopting a formula for distributing money to the counties and reservations for the aging programs.

The legislature intends that money distributed to each county and reservation for social services pursuant to Title IIIB of the Federal Older Americans Act must not be reduced to an amount less than that received by the county or reservation in the federal FY 81.

Available money for social services in addition to the amount received by the counties and reservations in the federal FY 81 must be distributed to the counties and reservations using the following formula:

(1) 60% of the funds distributed must be based on the population of people in the county or reservation who are 60 years of age and older;

(2) 20% of the funds distributed must be based on the minority population in the county or on the reservation who are 60 years of age and older; and

(3) 20% of the funds distributed must be based on the low-income population in the county or on the reservation who are 60 years of age and older.

Money distributed to each county or reservation for nutrition projects under Title $IIIC_1$ or $IIIC_2$ of the Federal Older Americans Act must not be reduced to an amount less than than received by the county or reservation in the federal FY 78.

Available money for the nutrition projects in addition to the amount received in the federal FY 78 must be distributed to the counties and reservations using the same formula as described above for social services.

PROPOSED AMENDMENTS TO HOUSE BILL 514

Amendment Ex.

1. Page 3, line 8.
Following: "requirements."
Strike: the rest of line 8 page 3, through line 19 in their entirety.
Insert:

(1) A person may obtain a certificate to practice midwifery by applying in writing to the department on a form supplied by the department, furnishing the required information, and fulfilling the requirements set forth in this section.

(2) The applicant for certification shall present to the department, at least 45 days prior to examination, written proof of graduation from high school or its equivalent as determined by the Office of Public Instruction.

(3) The applicant shall also present a certificate or diploma from a midwife training program approved by the Board, pursuant to this section (4).

(4) The Board shall set standards for approving a midwife training program which shall include but not be limited to the following areas:

a) anatomy, physiology, gynecology, genetics and embryology;
b) psychology
c) pre-natal care and screening of the high risk patient
d) nutrition
e) labor and its complications
f) asepsis
g) care of the new born
h) birth defects, infirmities and infections
i) family relations, parenting and preparation for childbirth
j) post-partum
k) hospital labor and delivery room procedures
l) ethics and responsibilities

(5) An applicant shall, in addition, present verification of participation in the prenatal care, delivery and post natal care of 20 women and infants under the supervision of a physician or certified midwife.

(6) The Board may require certification as an emergency medical technician.

(7) Except as provided in subsection (8) the person applying for certification must pass those written, oral and practical examinations that the board determines necessary.

And renumber subsequent sections.

2. Throughout the bill change the word "license" to "certificate."

3. Throughout the bill change the word "licensure" to "certification."

4. Page 4, line 14.
Following: "(b)"
Strike: the rest of line 14 through line 19 in their entirety.
Insert: prescribing requirements consistent with /sections 2 through 5/ and the laws of this state the duties, training, and limitations of the practice of midwifery;

5. Page 4, line 20.
Following: "(c)"
Strike: the rest of line 20 on page 4 through line 3 on page 5 in their entirety.
Insert: prescribing reasonable and necessary minimum qualifications for midwives; knowledge of those subjects in /section 4/; knowledge of the laws of the state concerning reporting of births and prenatal blood tests and of the regulations pertaining to midwifery.

6. AND: Language to indicate that nothing in this act shall be construed to allow certified midwives to practice in a public or private hospital setting.