MINUTES OF THE MEETING
HUMAN SERVICES AND AGING COMMITTEE
50TH LEGISLATIVE SESSION
HOUSE OF REPRESENTATIVES

The meeting of the Human Services and Aging Committee was called to order by Chairman R. Budd Gould, on February 17, 1987, at 12:30 p.m. in Room 312-D of the State Capitol.

ROLL CALL: All members were present except Rep. Cody.

CONSIDERATION OF HOUSE BILL NO. 752:

REP. CAL WINSLOW, House District No. 89, sponsor of the bill, stated the bill is called the Uniform Health Information Act. He said the bill came out of the National Conference of Commissioners of Uniform State Laws. He explained the bill is a repealer of a number of sections that deal with the health care confidentiality act, replacing it with the Uniform Health Care Information Act. He said it deals in a number of areas; 1) to allow disclosure to other persons for providing health care to a patient without the patients authorization to disclosure. 2) the area of who may have access to patient records, 3) if a patient requests information they are to receive it within a certain number of days, 4) it gives the health care facility the right to charge for those records, 5) if a physician puts something damaging in the records it allows the patients to have it taken out of their records, or at least have them file a statement of disagreement, that would continue with their files. He noted the uniform law had been worked on for three years by the American Medical Association, the American Hospital Association and others concerned in the area.

PROPONENTS:

BILL LEARY, representing the Montana Hospital Association. He stated after a quick review of the bill he had no problems with it and encouraged the committee to support the bill.

OPPONENTS: None.

REP. WINSLOW closed by saying he thought it was important that states unify some of their laws, especially in the area where there is so much health care moving from state to state.

QUESTIONS FROM THE COMMITTEE:

In response to a question from REP. KITSELMAN, REP. WINSLOW explained the bill gives the opportunity for an

individual to sign a statement that they do not want information released.

REP. SANDS questioned why there is a criminal penalty for purposefully disclosing information whereas there is no penalty provided for someone who refuses to provide information. REP. WINSLOW agreed that the penalty should be there also if the provider does not give the information.

CONSIDERATION OF HOUSE BILL NO. 749:

REP. CAROLYN SQUIRES, House District No. 58, sponsor of the bill, stated the bill is an act requiring the Department of Health and Environmental Sciences to make unannounced inspections to licensed health care facilities.

PROPONENTS:

ELSIE LATHAM, President of the Montana Senior Citizens Association, read her prepared statement in favor of HB # 749. See EXHIBIT # 1.

KAREN RICHEY, West Mont Home Health Care, rose in support of HB # 749. She said she believed that unannounced visits by state licencing agencies would be a method to increase the quality of care that goes on in any health care facility.

DR. JOHN J. DRYNAN, Director of the Department of Health and Environmental Sciences, rose in support of HB # 749. He said that unannounced inspections were done prior to the federal mandate.

BILL LEARY, Montana Hospital Association. He stated that the unannounced inspections conducted by the state department of health over the past 1 and 1/2 years have not been in any way restrictive to the ability of the hospitals to provide care and he would endorse the intent of HB # 749.

ROSE SKOOG, Montana Health Care Association, said this legislation indicates a commitment on the part of the state to conduct unannounced annual inspections.

ALICE CAMPBELL, Missoula. Ms. Campbell stated her mother is in the Hillside Rest Home in Missoula and that she believes the nursing homes are tipped off when an inspection is to be held. She spoke in favor of the bill.

DOUG BLAKLEY, State long-term care ombudsman. He said that unannounced inspections were the second priority for the legacy legislature. He stated it indicates a concern, especially by senior citizens, about the care that is being provided in facilities.

ELMER HAUSKIN, a volunteer unpaid registered lobbyist, representing the American Association of Retired Persons, read his prepared statement in support of HB # 749. See EXHIBIT # 2.

OPPONENTS: None.

REP. SQUIRES closed by reemphasizing the importance of the bill to the senior citizens and people in nursing homes and health care facilities.

QUESTIONS FROM THE COMMITTEE: None.

CONSIDERATION OF HOUSE BILL NO. 675:

REP. JOAN MILES, House District No. 45, sponsor of the bill, stated the bill proposes revisions of the indoor clean air act. She then handed out EXHIBIT # 3, a proposed amendment. She also referred to a fact sheet (pink) about the affect of tobacco smoke on non-smokers and a summary of what the law does now and how the bill proposes to change it. See EXHIBIT # 4. Rep. Miles also handed out a general fact sheet on some of the results of the Surgeon General's report. See EXHIBIT # 5.

REP. MILES noted on EXHIBIT # 4 that the smoking population of Montana was at 23%, so there is a situation where 70% of the population is non-smokers. She reviewed the bill in detail and said the amendment is to clarify the purpose of the indoor clean air act.

PROPONENTS:

EARL THOMAS, Executive Director of the American Lung Association of Montana, rose in support of HB # 675. A copy of his testimony is attached as EXHIBIT # 6. He stated that Carolyn Hamlin, President of the Montana Public Health Association had called him to ask him to register her support of the the bill and stated that a study reported in the Journal of Public Health showed that carbon monoxide levels are basically the same for smokers and for non-smokers when they share the same areas.

HERBERT G. STOENNER, Past President of the American Cancer Society, read his prepared statement in support of HB # 675. See EXHIBIT # 7.

FRANK CALDWELL, Director of the VA Regional Office and Center, Helena. He said the proposed bill is similar to the regulations that were approved in the federal register, which were published on Monday, Dec. 8, 1986. He then read a brief excerpt from the rules and regulations from the federal register, "Numerous studies have concluded that smoking adversely affects the health of those persons passively exposed to tabacco smoke". He said in view of those findings and in the interest of protecting federal employee health and well being, GSA proposed regulations to protect the non-smoking workers and public building visitors rights.

FRANK DAVIS, volunteer for the American Cancer Society, Great Falls, rose in support of HB # 675. A copy of his testimony is attached as EXHIBIT # 8.

DON ESPELIN, Pediatrician in Helena, rose in support of the bill. A copy of his testimony is attached as EXHIBIT # 9.

OPPONENTS:

JEROME ANDERSON, Billings, appearing on behalf of the Tobacco Institute in opposition to HB # 675. A copy of his testimony is attached as EXHIBIT # 10. Mr. Anderson said he had two witnesses who would discuss the various aspects of the controvery and the lack of necessity for legislation such as HB # 675. The first one was Dr. David Weeks, a medical Doctor from Boise, Idaho, who has appeared across the United States before legislative committees, and he will discuss the true import of the Surgeon General's report regarding passive smoking. He said Dr. Weeks would be followed by Simon Turner, an atmospheric chemist and ventilation expert associated with ACVA Atlantic Incorporated, a company that specializes in indoor air environment. He then handed out a client list for ACVA. See EXHIBIT # 11. Mr. Anderson then referred to a statement that discusses the Surgeon General's report and the report from the National Association of Sciences. See EXHIBIT # 12.

DR. DAVID WEEKS, Boise, Idaho, stated he had been following the issue of environmental tobacco smoke for three years. He noted that the Surgeon General and others had taken it as a personal agenda to eliminate smoking by the year 2000. He said he had no quarrel with that but should this committee or any other policy making body establish public

policy on the basis of the threat to the general public health, of environmental tobacco smoke, they would be doing themselves a disservice. He stated if you look at the science, the data of environmental tobacco smoke, the first report was issued by the National Academy of Sciences, National Research Council, a study group on tobacco smoke, and the second study is the Surgeon General's report. He said the reports were synoptic and come to the same conclusion. He submitted that the data did not support the conclusions reached in the two reports. Dr. Weeks said he believed that the major problem in indoor air was being overlooked - our buildings are energy efficient which turns down the ventilation and increases the exposure to viruses and other toxic chemicals.

SIMON TURNER, representing the company, ACVA Atlantic, rose in opposition to HB # 675. A copy of his testimony is attached as EXHIBIT # 13.

PHIL STROPE, representing the Montana Tavern Association and the Montana Innkeepers Association, said the bill is a sign painters relief bill. He said to pass this law is not going to change society's smoking habits, but enforcing the existing law might. He said the current law isn't enforced right in the Capitol. Mr. Strope proposed if the committee wanted to do something to make a smoke free society, they should appropriate some money to enforce the existing law.

JIM DURKIN, lobbyist, Great Falls, representing the Smoke Eaters of Montana, read his prepared statement in opposition to HB # 675. See EXHIBIT # 14. Mr. Durkin handed out a copy of clean air provisions that had been used in New Jersy and New York legislation which has helped smaller businesses stay alive. See EXHIBIT # 15.

CHAIRMAN GOULD requested that any further proponents or opponents please leave their name and written testimony because of the time shortage.

REP. MILES requested to yield her closing time for further proponents to be able to stand and give their name.

PROPONENTS (Continued):

DAVID LACKMAN, lobbyist for the Montana Public Health Association rose in support of the bill. See EXHIBIT # 16.

DEAN CENTER, family physician, Bozeman.

JERRY LOENDORF, Montana Medical Association, said the doctors of the State of Montana do support the bill.

BARB BOOHER, Executive Director of Montana Nurses Association, rose in support of the bill. A copy of her testimony is attached as EXHIBIT # 17.

CHUCK BUTLER, representing Blue Cross-Blue Shield of Montana submitted a copy of his company's anti-smoking policy for the committee. See EXHIBIT # 18.

LLOYD LINDEN, mortician, Helena. A copy of his testimony is attached as EXHIBIT # 19.

ELLIE HILPERT, Gt. Falls, Montana Heart Association, rose in support of HB # 675. See EXHIBIT # 20.

QUESTIONS FROM THE COMMITTEE:

REP. RUSSELL asked REP. MILES if she would address the discussion by the opponents that there are other factors involved besides tobacco smoke. REP. MILES replied that was an argument that she had expected to hear. She said she had just finished reading the document submitted by the Tobacco Institute, which is a rebuttal to the Surgeon General's report, and the main focus is that it is not the smoke that causes the problem, it is the ventilation system. She commented that the committee would be interested to know who had funded the study from the Tobacco Institute.

REP. RUSSELL then asked how expensive it would be to install the ventilators that Mr. Turner was suggesting. REP. MILES stated she did not know the answer to that.

REP. SIMON asked DR. Weeks if there was any verifiable data that would show that people do have allergic reactions to being in a passive smoke environment. Dr. Weeks replied that that data is not verifiable, that it is basically anecdote, that people experience difficulty in rooms, but it cannot be reproduced in a laboratory environment. REP. SIMON asked Dr. Weeks if he was suggesting that the reactions that the committee has heard about are all pyschosomatic. Dr. Weeks responded that two of the authors that he was aware of had come to that conclusion.

REP. SIMON asked when does society get to the point in time, since 75% of the population of the State of Montana are non-smokers, that the majority shall have some authority and can say the general buildings are non-smoking with designated smoking areas for the minority, rather than designating it the other way around? Dr. Weeks replied that

he began his testimony by saying if the purpose of this policy making body was to legislate the nuisance or asthetic value of cigarette smoke out of their existance, he had no quarrel with that, but if it was to base public policy on the basis of good scientific data in the interest of public health at large, then he would ask the committee to use caution.

CONSIDERATION OF SENATE BILL NO.31:

SENATOR JUDY JACOBSON, Senate District No. 36, co-sponsor of the bill with REP. GILBERT, stated the bill was to allow direct patient access to physical therapy. She said this would eliminate referrals by physicians in some cases. The Montana Medical Association expressed concern about the bill being wide open and added the following amendments, which the physical therapists concurred with. 1) to add a physician and a public member to their board, increasing their board from 3 members to 5 members. She said the MMA would submit the nominees to the governor for the physician that would go on the board. 2) to have a mandatory reporting by physical therapists in hopes of strengthening their board.

PROPONENTS:

DR. PEGGY SCHLESINGER, Great Falls. She stated that she cares for people who have arthritis, including the majority of the children in Western Montana who have arthritis. And that all of the children who have arthritis are seen by physical therapists, and she has come to have great respect for the abilities and integrity of the physical therapists in Montana. She stated she supports the bill for two reasons, 1) it gives physical therapists more direct access to patients, and 2) it gives patients the opportunity to benefit from physical therapists without waiting for a physician's referral.

REP. LES KITSELMAN, House District No. 95, said he was speaking as parent of a son who undergoes physical therapy. He stated he felt it was ludicrous to have to get a prescription from a Doctor in order to have his son be able to get the physical therapy that he needs at the Eastern Montana Clinic.

MARY MISTAL, Physical Therapist, Billings, also representing the Montana Chapter of the American Physical Therapy Association gave the history of physical therapy. See EXHIBIT # 21.

DR. AIMEE V. HACHIGIAN, Orthopedic Surgeon, Great Falls. Dr. Hachigian related the amount of training a physical therapist receives compared to the amount of training that she had received in the field, and asked the committee who was better qualified to practice physical therapy. She stated that physical therapists are highly trained in their ability to recognize injuries that require surgical intervention. She strongly supported the bill.

CLEVELAND SMITH, Podiatrist, Helena, rose in support of the physical therapists. He said he believed fully in their abilities and their judgement.

MAUREEN STRAZDAS, Helena, a patient of Dr. Schlesinger and also of Cheryl Hanson, a physical therapist, spoke in support of direct access to a physical therapist.

JERRY LOENDORF, Montana Medical Association, spoke in support of sections 1 and 2 of the bill. He stated that being part of a profession is not just being licensed, but that there is a commensurate duty that goes with it and that is to to insure that the profession is always performing for the benefit of society. He noted that section 1 of the bill expands the board to include two new members, and that section 2 requires physical therapists to report to the board any other physical therapist who is no longer able to safely engage, either for mental or physical reasons to practice physical therapy, that it also requires the physical therapist to report to the board anything they note which may be grounds for discipline, based on some act or ommission a physical therapist may have participated in. He stated this particular provision applies only to physicians now, but that it should apply to all professionals.

BILL LEARY, representing the Montana Hospital Association. Mr. Leary said the MHA had taken a neutral position when the bill was in the Senate and had not changed their position. He then related to the committee that his son was a physical therapist at his own sports medicine clinic in California, where this bill is currently the law. He then explained to the committee that his son does an assessment on his patients, asking them who their attending physician is, and completes a very comprehensive report to the physician on the patient. He then stated he felt this was an excellent bill and Montana should join the 11 other states that already have direct access to physical therapists.

RICHARD GAJDOSIK, Associate Professor, representing the Physical Therapists at the University of Montana. He rose

in support of the bill. A copy of his testimony is attached as EXHIBIT # 22.

MONA JAMISON, lobbyist for the Montana Chapter of the American Physical Therapy Association. She handed out letters from doctors and physical therapists who were unable to attend the hearing in support of SB # 31. See EXHIBITS 23,24,25 and 26. She also handed out a letter from the major insurer that provide malpractice insurance for physical therapy, which states that in the 13 states where this law has been enacted there has not been an increase in premiums or in complaints, see EXHIBIT # 27. Ms. Jamison then referred to a letter that was submitted by Dr. Kenneth Eden, Helena physician, stating that the present law is unrealistic and discriminates unfairly against physical therapists. See EXHIBIT # 28. She also noted she had submitted a letter stating it was not the intent of this legislation to change the law which requires direct payments to physical therapists. See EXHIBIT # 29.

REP. BOB GILBERT, House District NO. 22, referred to the flyer entitled "Opening the Door to Physical Therapy", see EXHIBIT # 30, which shows that physical therapy is the only profession that is required to have a physician's referral. That there are many professions that are not licensed that do not require referrals. He noted that physical therapists are licensed in all 50 states, they are controlled, have been in business for many years and give excellent service. He urged the committee's approval of the bill.

OPPONENTS:

DAVID GRAY, practicing chiropractor, Missoula, said he was appearing with mixed emotions and some reluctance to speak as an opponent on the measure. He said the time is now for physical therapists to be recognized in their specialties. He noted that there had been testimony from a licensed orthopedic surgeon regarding the small amount of training that physician receive in the rendering of physical therapy, and that he agreed that a physical therapist is a highly trained individual that administers a tool of medicine.

He stated there is an issue that had not been brought out, and this is for a physical therapist to embark on a portal of entry care, he does not have the training that a physician, osteopath or chiropractor has in diagnostic evaluation. He suggested that the physical therapist embark upon some kind of re-educational program to expand their

basic knowledge of the working of the human body equal to those demands that are made upon the portal of entry physicians.

DR. LEE HUDSON, member of the Board of Directors of the Montana Chiropractic Association, read his prepared statement, see EXHIBIT # 31, and also some exerpts from the Chiropractic report in New Zealand, see EXHIBIT # 32.

GARY BLOM, Helena, President of the Montana Chiropractic Association, read his prepared statement, see EXHIBIT # 33.

BONNIE TIPPY, representing the Montana Chiropractic Association read her prepared statement in opposition to SB # 31, see EXHIBIT # 34. Ms. Tippy then submitted an amendment to the bill which reads, " NEW SECTION, Section 4, Direct access certificate--prerequisite--provisional issuance. The board shall, upon request, issue a direct access certificate to any of its licensees who holds a master's degree or has completed equivalent academic study of physicial therapy beyond the bachelor's degree in physical therapy. Prior to October 1, 1988, the board may issue a provisional direct access certificate to any of its licensees who holds a bachelor's degree in physical therapy and who has worked in this state as a physical therapist for at least one year. Those persons granted provisional direct access certificates must earn the master's degree in physical therapy within 5 years after October 1, 1987. Physical therapists holding provisional direct access certificates who have not qualified for the direct access certificate by October 1, 1992 may not thereafter provide treatment without referral under 37-11-104 (2), but may continue to perform physical therapy evaluation without referral and physical therapy treatment with referral from a physician, osteopath, dentist, or podiatrist." Ms. Tippy also submitted a list of Universitites that offer Masters Degrees in Physical Therapy. See EXHIBIT # 35.

SENATOR JACOBSON closed by noting that although she had been working closely with all of the people who testified, she had not been aware that there was a proposed amendment to the bill until the hearing today. She then reminded the committee that the Montana Medical Association was in agreement with the bill, although some physicians may not be. She also commented there had been testimony that this law was unprecedented. She stated that the legislature had given the same privilege to the occupational therapists during the 1985 session. She concluded with stating she felt it was a fair bill and that the physical

therapists should not be discrimated against as far as other groups are concerned. She asked the committee to ignore the amendment that had been submitted because she didn't think it was necessary, timely or had a lot to do with the bill.

QUESTIONS FROM THE COMMITTEE:

In response to a question from REP. NELSON, SENATOR JACOBSON stated the physical therapists would welcome a medical physician on their board.

In response to a question from REP. HANSEN, Dr. Aimee Hachigian stated she did not beliee that gaining a master's degree would give a physical therapist that much more expertise in providing treatment. She said she would like to remind the committee in talking about the difference in the number of hours that a chiropractor has versus the number of hours that a physical therapist has, that the chiropractor is trained in spinal manipulation, whereas a physical therapist is trained in the treatment of the entire muscular skeletal system, all of the bones and joints in the body, and in the rehabilitation of those parts, and that is the very real difference between the two disciplines.

ADJOURNMENT: There being no further business to come before the committee the meeting was adjourned at 2:50 p.m.

R. BUDD GOULD, CHAIRMAN

DAILY ROLL CALL

HUMAN SERVICES AND AGING COMMITTEE

50th LEGISLATIVE SESSION -- 1987

Date FEBRUARY 17, 1987
12:30 P.M.

NAME	PRESENT	ABSENT	EXCUSED
REP. BUDD GOULD, CHAIRMAN	X		
REP. BOB GILBERT, VICE CHAIRMAN	X		
REP. [illegible]N BROWN	X		
REP DUANE COMPTON	X		
REP. DOROTHY CODY		X	
REP. DICK CORNE'	X		
REP. LARRY GRINDE	X		
REP. STELLA JEAN HANSEN	X		
REP. LES KITSELMAN	X		
REP. LLOYD MC CORMICK	X		
REP. RICHARD NELSON	X		
REP. JOHN PATTERSON	X		
REP. ANGELA RUSSELL	X		
REP. JACK SANDS	X		
REP. BRUCE SIMON	X		
REP. CAROLYN SQUIRES	X		
REP. TONIA STRATFORD	X		
REP. BILL STRIZICH	X		

CS-30

Montana Senior Citizens Assn., Inc.

WITH AFFILIATED CHAPTERS THROUGHOUT THE STATE

P.O. BOX 423 · HELENA, MONTANA 59624

406 443 5341

Testimony Presented Before the Human Services Committee, February 17, 1987

Mr. Chairman and Members of the Commiittee:

For the record I'm Elsie Latham, President of the Montana Senior Citizens Association. Our organization of over 7000 members across the state support HB 749 that calls for unannounced inspections of all licensed health care facilities on an annual basis.

We're aware that these inspections are being done now as the Health Care Financing Administration dictates but we feel it is vital for the state law to require that the inpsections be done on an unannounced basis.

We feel that this law will service as a safeguard for the citizens of Montana who need to use these facilities and that their care will be assured. So we urge you to give this bill a "do pass" recommendation.

Elsie Latham

EXHIBIT [illegible]
DATE [illegible]
HB # 749

WITNESS STATEMENT

NAME [illegible] BILL NO. HB 749

ADDRESS [illegible] Highland

WHOM DO YOU REPRESENT? AARP [illegible]

SUPPORT ✓ OPPOSE ______ AMEND ______

COMMENTS: [illegible] AARP [illegible] Montana.

In the interest of maintaining the highest quality of care possible I urge you to oppose HB 749 for the maintenance & inspections of Health Care facilities. Thank the Chairman and members of this committee.

PLEASE LEAVE PREPARED STATEMENT WITH SECRETARY.

Form CS-34
Rev. 1985

EXHIBIT 11-3
DATE 2-11-91
HB 675

AMENDMENT TO HOUSE BILL 675
(requested by sponsor)

1. Page 1, lines 19 through 21.
Following: "protect"
Strike: remainder of line 19 through "choose to" on line 21
Insert: "and promote public health by reducing involuntary exposure to tobacco"
Following: "places"
Insert: "and to allow a proprietor, manager, or person in charge of an enclosed public place to reserve an area for persons who choose to smoke"

Result

"50-40-102. Purpose. The purpose of this part is to protect ~~the health of nonsmokers in public places and to provide for reserved areas in some public places for those who choose to~~ AND PROMOTE PUBLIC HEALTH BY REDUCING EXPOSURE TO TOBACCO smoke in enclosed public places AND TO ALLOW A PROPRIETOR, MANAGER, OR PERSON IN CHARGE OF AN ENCLOSED PUBLIC PLACE TO RESERVE AN AREA FOR THOSE WHO CHOOSE TO SMOKE."

EXHIBIT
DATE 2-17-87
HB #1,75

FACT SHEET
February 13, 1987

Smoking Prevalence in Montana, 1983- 1986 Behavioral Risk Surveys
(Current Smokers)

	1983	1984	1985	1986
Total	25.7	28.3	24.55	23.0
Male	29.9	29.3	24.3	23.4
Female	21.5	27.2	24.8	22.6

Source: Montana Behavioral Risk Survey, Montana Department of Health And Environmental, 1983-86

Health Risks

Smoking is the single largest preventable cause of premature death/disability in the United States.

Every year 350,000 Americans or 1,000 per day die prematurely from the effects of cigarette smoking - Smoking accounts for six times more deaths than motor vehicle accidents.

It is estimated that 85% of lung cancer deaths among men and 75% among women - about 83% overall - are due to smoking.

Smoking accounts for 19% of all deaths in the United States and 30% of all cancer deaths.

Involuntary smoking is a cause of disease, including lung cancer, in healthy nonsmokers.

Simple separation of smokers and nonsmokers within the same air space may reduce, but does not eliminate, ETS exposure.

Costs

An average one-pack-plus-per-day smoker over a lifetime will cost an employer $438 - $784 per year, including medical insurance costs, fire loss, worker's comp, life insurance, absenteeism, decreased productivity.

19% of all absenteeism has been attributed to smoking related illnesses.

Smokers are 50% more likely to be hospitalized than nonsmokers.

Public Attitudes

According to a November 1986 survey by ALA, ACS, AHA -

The public overwhelmingly endorses having "No Smoking" sections in public places, such as restaurants, airplanes and trains. 94% felt public places should have "No Smoking" sections. 84% favored allowing employers to limit smoking locations.

EXHIBIT 5
DATE 2-17-87
HB 675

TRI-AGENCY COALITION for a TOBACCO FREE
MONTANA by the YEAR 2000

Member Agencies

AMERICAN CANCER SOCIETY	AMERICAN HEART ASSOC.	AMERICAN LUNG ASSOC.
Montana Division	Montana Affiliate	of Montana
Public Issues Chairman	Executive Director	Executive Director
Frank Davis	Madelyn Moore	Earl Thomas

TO: Members of the Human Services and Aging Committee
Montana State House of Representatives

SUBJECT: Hearing on Tuesday, February 17, 1987 on:
HB 675, Sponsor Joan Miles and others, Revising and Clarifying The Montana Clean Indoor Air Act.

As a coalition representing several thousand concerned volunteers in Montana, we would like to present data from the Surgeon Generals 1986 report on the health consequences of smoking tobacco...especially as it applies to the involuntary inhalation of tobacco smoke by a non-smoker from the breath or burning tobacco of a smoker in a closed public area.

Surgeon General C. Everett Koop, M.D. stated:

...30 years of research conducted in over 80 countries has generated 50,000 studies on smoking or health--the case against smoking is "air-tight".

...Attention has turned toward effects of sidestream smoke--the cigarette smoke that non-smokers inhale involuntarily from the ambient air.

There are over 4000 components of cigarette smoke--sidestream or mainstream--including the following toxic substances.

...tars, napthalene, pyrene, benzopyrene, carbon monoxide, mehtane, ammonia, acetylene, and hydrogen cyanide.

...Some of these toxic substances are found in greater concentration in sidestream smoke than in mainstream smoke:

...tar--the most carcinogenic substance--is 70% more concentrated in sidestream smoke.

...carbon monoxide is 2.5 times greater in sidestream smoke.

...nicotine is 2.7 times greater in sidestream smoke.

...ammonia is 73 times greater in sidestream smoke.

We hope the above facts will help decide your vote on this proposed legislation. It is very important to the health of the public that this bill receives favorable consideration. We thank you for reading this and for hearing our testimony on Tuesday.

Note: Complete copies of the Surgeon General's report will be made available to the Secretary of this Committee.

EXHIBIT # 16
DATE 2-17-87
HB # 675

I AM EARL THOMAS, EXECUTIVE DIRECTOR OF THE AMERICAN LUNG ASSOCIATION OF MONTANA. SPEAKING ON BEHALF OF THE AMERICAN LUNG ASSOCIATION AND THE COALITION OF MONTANANS FOR A TOBACCO FREE MONTANA BY THE YEAR 2000 OF WHICH I AM PRESIDENT. WE SUPPORT HB 675 WHICH REVISES MONTANA'S CLEAN INDOOR AIR ACT. THREE MAJOR REVISIONS ARE:

I. ENCLOSED PUBLIC PLACES WOULD BE TOTALLY SMOKE FREE BUT WOULD HAVE THE OPTION OF PROVIDING A SMOKING AREA FOR THE 23% OF THE POPULATION OF MONTANA WHO SMOKE.

WE SUPPORT THIS CHANGE BECAUSE WE DO NOT BELIEVE THE NONSMOKERS SHOULD BE THE ONES SEEKING A SMOKEFREE AREA.

II. PROVIDE A SMOKEFREE WORK AREA FOR ANYONE WORKING IN A PUBLIC PLACE NOT JUST FOR STATE EMPLOYEES.

WE SUPPORT THIS BECAUSE WE ARE AWARE OF THE DEMAND BY NON SMOKING WORKERS FOR A SMOKE FREE WORK ENVIRONMENT. THE GREATEST EXPOSURE TO ENVIRONMENTAL TOBACCO SMOKE IS AT THE WORKPLACE. MOST OF US THROUGH FREEDOM OF CHOICE MAY AVOID SMOKE BUT NOT AT THE WORKPLACE.

III. STRONGER ENFORCEMENT - THE HIGHER FINES WOULD MAKE IT MORE ENFORCEABLE.

WE SUPPORT THE INCREASED FINE BECAUSE IT WILL INCREASE COMPLIANCE AND MAKE IT A SELF ENFORCING LAW - MOST CITIZENS ARE LAW ABIDING BUT WE ALL NEED TO KNOW THE RULES. THE SAME AS WE NEED TO KNOW THE RULES ABOUT HANDICAPPED PARKING.

IN CONCLUSION, I URGE YOU TO SUPPORT HB 675 BECAUSE IT IS WANTED BY THE MAJORITY. THE 77% OF THE POPULATION WHO DO NOT SMOKE. WE HAVE ALL BEEN HEARING ABOUT THE SEAT-BELT LAW WHICH PROTECTS US AGAINST OURSELVES - CIGARETTES CAUSE SIX TIMES AS MANY DEATHS AS VEHICLE ACCIDENTS. LOOK AT THE RESULTS OF DRUNK DRIVING LEGISLATION. IT PROTECTED US AGAINST OURSELVES AND AGAINST EACH OTHER. YOU MAY QUESTION WHY DO WE WANT STRONGER LEGISLATION

EXHIBIT
DATE
HB

WITNESS STATEMENT

NAME Herbert G. Stoenner, Past President, Montana Division, ACS BILL NO. HB675

ADDRESS 1102 S. 2nd Street, Hamilton, MT 59840 DATE 1-28-87

WHOM DO YOU REPRESENT? American Cancer Society, Montana Division

SUPPORT X X X OPPOSE _____ AMEND _____

PLEASE LEAVE PREPARED STATEMENT WITH SECRETARY. HB 675 (Miles)
Revising & clarifying Clean Indoor Air Act. House
Comments: Human Services. Rm 312 D 2:30 P.M. 2/17/87
(Gould)

In 1986, about 300,000 Americans died from the effects of long-term cigarette smoking - chiefly from lung cancer, emphysema, stroke and heart attacks. Many studies have conclusively shown that cigarette smoking causes 80 to 90% of lung cancer and 30% of all kinds of cancer. The latest to be associated with smoking is pancreatic cancer, which has nearly a 100% fatality rate. Deaths from lung cancer in women now exceed those from breast cancer.

Last year the Surgeon General of the Public Health Service warned the public that cigarette smoking is the chief industrial health hazard in this country. Twenty-five percent of lung cancer among non-smokers has been shown to be caused by inhalation of sidestream smoke. Many persons allergic to tobacco toxins develop acute asthmatic attacks from a very brief exposure to tobacco smoke. Clearly, sidestream tobacco smoke is a health hazard to non-smokers.

The combined number of non-smokers and ex-smokers has steadily increased, and in 1985 only 33% of men and 28% of women still smoked. Hence a smoking minority should not have the right to impose a health hazard on a non-smoking majority. Smoking in public buildings should be banned or so controlled that non-smokers have access to an area free of tobacco smoke.

WHEN SO MUCH HAS ALREADY BEEN DONE VOLUNTARILY IN THE WORKPLACE AND PUBLIC AREAS. I BELIEVE STRONG CLEAR LEGISLATION IS NEEDED SO ALL WILL BE PLAYING BY THE SAME RULES. WE HAVE RECEIVED NUMEROUS REQUESTS TO DEVELOP SMOKING POLICIES. TWO RECENT REQUESTS POINT THIS OUT.

FRED MEYERS STORES IN WESTERN MONTANA WANTED TO ESTABLISH SMOKING POLICIES IN THEIR STORES FOR EMPLOYEES AND CUSTOMERS BUT WERE CONCERNED WHAT REGULATIONS THE COMPETING STORES WERE USING.

A SCHOOL IN NORTHEASTERN MONTANA WANTS TO ESTABLISH A SMOKING POLICY FOR TEACHERS BUT WAS CONCERNED ABOUT IT BEING LEGAL.

WE NEED SIGNS TO DRIVE BY TO OBEY THE LAWS. HB 675 WILL PROVIDE THE SIGNS TO SMOKE BY AND PROVIDE A SMOKE FREE ENVIRONMENT FOR THOSE WHO CHOOSE IT.

CAROLYN HAHLIN - PRESIDENT OF THE MONTANA PUBLIC HEALTH ASSOCIATION - CALLED TO SAY SHE WAS UNABLE TO TESTIFY BUT SHE SUPPORTS HB 675 AND QUOTED A STUDY REPORTED IN THE JOURNAL OF PUBLIC HEALTH THAT SHOWED THAT CARBON MONOXIDE LEVELS ARE BASICALLY THE SAME FOR SMOKERS AND NONSMOKERS WHEN THEY SHARE THE SAME AREA.

EXHIBIT
DATE
HB

TESTIMONY ON H.B. #675 Revise and Clarify the Montana Clean Indoor Air Act.

By: Frank [illegible] Davis
Volunteer, Montana Division, American Cancer Society
Great Falls, Montana

(1). I would like to bring to your attention these facts in regards the disease of Cancer and how tobacco smoke increases the risk of contracting this disease. FROM: Cancer Facts and Figures, published by the American Cancer Society: 963,000 new cancer cases will be diagnosed in 1987, (in the United States) 483,000 will die of the disease. Lung Cancer still holds 1st place as the leading cancer killer for men and women.

(2). From C. Everett Koop, M.D., Surgeon Generals Report on Smoking, December 16, 1986: Involuntary exposure to tobacco smoke increases the risk of lung cancer by 30%. Among those heavily exposed (20 or more cigarettes a day) the risk increases to 100 %.

(3). Some people may say that we in Montana do not need further regulations. That we are over regulated now. This could be true if all people acted with complete responsibility and with full respect for others. Why did we need to strengthen the law against driving under the influence of alcohol? Only because all people do not act in the best interest of others. They do not respect the rights of others. Now if I were given the choice of tragedies between being involved in a car accident with a drunk driver or contracting lung cancer from the smoke off a burning cigarette, I know I would not choose the latter.

The American Cancer Society urges the legislators of Montana to join the many other states that are attempting to strengthen their Indoor Clean Air Acts. I hope you will see fit to deliver this bill to the house with a do pass recommendation. I thank you for listening to the reasons I have given for your favorable consideration.

EXHIBIT #1
DATE 2-17-87
HB #675

TO THE HOUSE COMMITTEE ON HUMAN SERVICES AND AGING

TESTIMONY IN SUPPORT OF HB 675

February 17, 1987

For the record, I am Donald E. Espelin, M.D., pediatrician in Helena.

Mr. Chairman, I wear many hats. I am a concerned citizen; charter member of the Montana Chapter of the American Academy of Pediatrics; Program Manager of the Montana Perinatal Program, Department of Health and Environmental Sciences; and Bureau Chief of the Preventive Health Services Bureau, Department of Health and Environmental Sciences. Most importantly, I am an ex-smoker. I am here today on my own time to support House Bill 675. As an ex-smoker, I have abused people with my secondhand smoke for over 30 years. This has lead me to two open heart surgeries involving 9 coronary bypasses.

1986 Surgeon General's Report:

The Health Consequences of Involuntary Smoking

Inhalation of tobacco smoke during active cigarette smoking remains the largest single preventable cause of death and disability in the United States. The health consequences of cigarette smoking and of the use of other tobacco products have been extensively documented in the 18 previous Surgeon General's reports issued by the Public Health Service. More than 300,000 premature deaths that are directly attributable to tobacco smoke use --- particularly cigarette smoking --- occur each year in the United States. The magnitude of the disease risk for active smokers, secondary to their high dose exposure to tobacco smoke, suggests that the lower doses of smoke received by involuntary smokers also puts them at risk. The 1986 Surgeon General's Report explores the health consequences incurred by involuntary smokers. It was developed by

the Office on Smoking and Health, Center for Health Promotion and Education, Centers for Disease Control (CDC) as part of the U.S. Department of Health and Human Services' responsibility under Public Law 91-222 to report new and current information on smoking and health to the U.S. Congress.

Data in the 1986 report present evidence that the chemical composition of sidestream smoke (smoke emitted into the environment by a smoker between puffs) is qualitatively similar to the mainstream smoke inhaled by the smoker and that both mainstream and sidestream smoke act as carcinogens in bioassay systems (1). Data on the environmental levels of the components of tobacco smoke and on nicotine absorption in nonsmokers suggest that nonsmokers are exposed to levels of environmental tobacco smoke (ETS) that would be expected to generate a lung cancer risk. In addition, epidemiological studies of populations exposed to ETS have documented an increased risk for lung cancer in those nonsmokers with increased exposure. Of the 13 epidemiological studies that were available for review in the scientific literature, 11 reported a positive relationship and six of these observed statistically significant results. It is rare to have such detailed exposure data or human epidemiologic studies on disease occurrence when attempting to evaluate the risk of low-dose exposure to an agent with estabilished toxicity at higher levels of exposure. The relative abundance of data reviewed in the report, their cohesiveness, and their biologic plausibility allow a judgment that involuntary smoking can cause lung cancer in nonsmokers.

The 1986 Surgeon General's Report comes to three major conclusions:

· Involuntary smoking is a cause of disease, including lung cancer, in healthy nonsmokers.

· Compared with children of nonsmoking parents, children whose parents smoke have an increased frequency of respiratory symptoms and infections. They

also have slightly smaller rates of increase in lung function as the lung matures.

• Simple separation of smokers and nonsmokers within the same air space may reduce, but does not eliminate ETS exposure.

The report also reviews policies restricting smoking in public places and the workplace and states that, in the 1970s, an increasing number of public and private sector institutions began adopting policies to protect individuals from ETS exposure by restricting the circumstances in which smoking is permitted. Local governments have been enacting smoking ordinances at an increasing rate since 1980. Restrictions on smoking at the workplace have resulted from both governmental action and private initiative, and an increase in workplace smoking policies has been a trend of the 1980s. Laws restricting smoking in public places have been implemented with few problems and at little cost to state and local governments. Public opinion polls document strong and growing support for restricting or banning smoking in a wide range of public places.

The Surgeon General, in his preface to the report, states, "Cigarette smoking is an addictive behavior, and the individual smoker must decide whether or not to continue that behavior; however, it is evident from the data presented in this volume that the choice to smoke cannot interfere with the nonsmokers' right to breathe air free of tobacco smoke."
(Reported by Office on Smoking and Health, Center for Health Promotion and Education, CDC.)

EDITORIAL NOTE: A review recently published by the National Academy of Sciences states that approximately 20% of the estimated 12,200 lung cancer deaths occurring annually in nonsmokers are attributable to environmental tobacco smoke (2). This estimate falls close to the mid-point of the range

published by Repace and Lowery, who state that between 500 and 5,000 lung cancer deaths may occur annually as a result of nonsmokers' exposure to tobacco smoke (3). By comparison, figures published in the Journal of the Air Pollution Control Association estimate that between 1,300 and 1,700 total cases of cancer resulting from other air pollutants in the general environment occur each year in the United States (4). Thus, while the number of lung cancer deaths that may be related to ETS exposure is small compared with those caused by active smoking, the actual number of lung cancer deaths caused annually by involuntary smoking is large. In addition, ETS causes more cases of cancer annually than many other agents in the general enviornment that are regulated because of their potential to cause disease.

References

1. Office on Smoking and Health. The health consequences of involuntary smoking: a report of the Surgeon Genernal. Rockville, Maryland: Public Health Service, 1986.

2. National Research Council, National Academy of Sciences. Environmental tobacco smoke: measuring exposures and assessing health effects. Washington, D.C.: National Academy Press, 1986.

3. Repace JL, Lowrey AH. A quantitative estimate of nonsmokers' lung cancer risk from passive smoking. Environ Int 1986; 11:3-22.

4. Thomson VE, Jones A, Haemisegger E, Steigerwald B. The air toxics problem in the United States: an analysis of cancer risks posed by selected air pollutants. J Air Pollut Control Assoc 1985; 35(5):535-40.

EXHIBIT # 10
DATE 2-17-87
HB 675

Jerome Anderson
2555 Ferndale, Unit #111
Helena, MT 59601
406-443-3605

February 17, 1987

Dear Committee Member:

This letter is sent to you on behalf of the Tobacco Institute, which I represent, to urge your opposition to H.B. 675.

H.B. 675, a bill introduced for the purpose of amending the Montana Clean Air Act, places additional restrictions on Montana businessmen and building owners. It constitutes further harassment of such businessmen and discrimination against those Treasure Staters who exercise their constitutional right of freedom of choice.

The present Montana Clean Air Act, a copy of which is attached for your information, regulates smoking in various enclosed public places by designating non-smoking and in some cases smoking areas in certain specified locations (Sec. 50-40-104 MCA). In establishments containing both a restaurant and a tavern where patrons choose to eat meals in the tavern, the proprietor is not required to post signs relative to the designation of non-smoking areas (Sec. 50-40-104 MCA). Certain specified locations are now required to be designated as non-smoking areas (Sec. 50-40-105, MCA). Additional restrictions including certain prohibitions against smoking apply to health care facilities such as hospitals (Sec. 50-40-106, MCA). Restrooms, taverns or bars where meals are not served and vehicles or rooms seating six or fewer members of the public are exempt from the act (Sec. 50-40-108 MCA). Violations of the Act are specified to be a misdemeanor and a fine of up to $25.00 may be assessed.

Essentially, H.B. 675, a copy of which is attached for your convenience, would require proprietors, et al to specify and designate "smoking areas" rather than "non-smoking" areas in their establishments or in enclosed locations that are open to the public. This somewhat innocuous sounding change in the Act would have far reaching consequences in the sense that everyone operating a facility subject to the Act would be required to completely redesignate areas in their establishments and remove present signs and replace them with new signs specifying the new designations. These requirements would dictate needless expenditures and unnecessary disruption of existing facilities.

The present form of the Act is being observed across Montana. It was last amended in 1985 and proprietors have, therefore, relatively recently changed their operations to conform to those amendments. Segregated areas are now available in establishments in Montana. Why is it necessary to further amend the Act to simply change areas from "Non-smoking" areas to "Smoking areas"? We don't believe anything will be accomplished other than to cause additional unnecessary expense and harassment to business and facility owners.

H.B. 675 contains some additional amendments to the Act that are more restrictive in some areas and are more punitive in nature. The fine for violating the act by failing to properly designate areas, et al is increased from a maximum of $25.00 to a maximum of $100.00 and each day of violation would constitute a separate offense so that if a proprietor were, for some reason, in violation for seven days, a fine of $700.00 could be levied. If a person should happen to knowingly smoke in an enclosed public space that is not designated as a "Smoking Area", he could be arrested and fined up to $50.00.

H.B. 675 is not necessary in Montana. We have a present Act that is working. If H.B. 675 passes, needless redesignation of areas and re-signing of locations would be required. Why make petty criminals out of people who now exercise their freedom of choice with understanding and acknowledgment of the desires of others in the community?

We urge you to vote against H.B. 675.

Sincerely yours,

Jerome Anderson
Representing the Tobacco
Institute

House BILL NO. 675

INTRODUCED BY

A BILL FOR AN ACT ENTITLED: "AN ACT GENERALLY REVISING AND CLARIFYING THE MONTANA CLEAN INDOOR AIR ACT; REQUIRING THAT A NONSMOKING AREA BE DESIGNATED IN EVERY ENCLOSED PUBLIC PLACE AND THAT SMOKING BE PROHIBITED IN THE WORK AREA OF NONSMOKERS IN SOME PLACES OF WORK; FINING A PERSON WHO SMOKES IN A DESIGNATED NONSMOKING AREA AND INCREASING THE FINE FOR FAILURE TO DESIGNATE A NONSMOKING AREA; ALLOWING AN INJUNCTION TO BE SOUGHT TO ENFORCE COMPLIANCE WITH THE ACT; AMENDING SECTIONS 50-40-102 THROUGH 50-40-105 AND 50-40-107 THROUGH 50-40-109, MCA; AND REPEALING SECTION 50-40-201, MCA."

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MONTANA:

Section 1. Section 50-40-102, MCA, is amended to read:

"50-40-102. Purpose. The purpose of this part is to protect the health of nonsmokers ~~in public places~~ and to provide for reserved areas ~~in some public places~~ for those who choose to smoke in enclosed public places."

Section 2. Section 50-40-103, MCA, is amended to read:

"50-40-103. Definitions. As used in this part, the following definitions apply:

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

(2) "Enclosed public place" means 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, and assembly and meeting rooms open to the public.

(3) "Establishment" means an enterprise under one roof that serves the public and for which a single person, agency, corporation, or legal entity is responsible.

(4) "Nonsmoking area" means a designated area in which smoking is prohibited.

~~(4)~~(5) "Person" means an individual~~, partnership, corporation, association, political subdivision, or other entity~~.

~~(5)~~(6) "Smoking" or "to smoke" includes the act of lighting, smoking, or carrying a lighted cigar, cigarette, pipe, or any smokable product.

~~(6)~~(7) "Smoking area" means a designated area in which smoking is permitted.

~~(7)~~(8) "Place of work" means an enclosed room where more than one employee works."

Section 3. Section 50-40-104, MCA, is amended to read:

"50-40-104. Designation or reservation of smoking or

INTRODUCED BILL
HB 675

nonsmoking areas -- notice. (1) Except for those enclosed public places provided for in 50-40-105 and as provided in 50-40-201 taverns or bars where meals are not served, the proprietor, or manager, or person in charge of an establishment containing an enclosed public place shall:

(a) designate nonsmoking areas with easily readable signs; or

(b)(a) reserve a part of the public place for nonsmokers smokers and post easily readable signs designating a smoking area; or

(c)(b) designate the entire area enclosed public place as a smoking nonsmoking area by posting a sign that is clearly visible to the public stating this designation; and

(2)(c) The proprietor or manager of an establishment containing enclosed public places shall post a sign in a conspicuous place at all public entrances to the establishment stating, in a manner that can be easily read and understood, whether or not areas within the establishment have been reserved for nonsmokers smokers.

(3)(2) The proprietor, or manager, or person in charge of an establishment containing both a restaurant and a tavern, in which some patrons choose to eat their meals in the tavern, is not required by this part to designate the areas or post a sign the signs described in subsection (2)(1) in the tavern area of the establishment.

(3) The manager or person in charge of an enclosed public place that functions primarily as an office or other place of work rather than to provide personal service and access to the general public must designate as a nonsmoking area a portion of the place of work large enough to include the customary work areas of all nonsmoking employees assigned to that place of work."

Section 4. Section 50-40-105, MCA, is amended to read:

"50-40-105. No smoking signs in certain places. No smoking signs shall be conspicuously posted in elevators, museums, galleries, kitchens, restrooms, and libraries of any establishment doing business with the general public."

Section 5. Section 50-40-107, MCA, is amended to read:

"50-40-107. Exemptions Exemption. The following shall be Taverns or bars where meals are not served are exempt from this part:

(1) restrooms;

(2) taverns or bars where meals are not served;

(3) vehicles or rooms seating six or fewer members of the public."

Section 6. Section 50-40-108, MCA, is amended to read:

"50-40-108. Enforcement -- injunction. (1) The provisions of this part shall be supervised and enforced by the local boards of health under the direction of the department Local boards of health must supervise and enforce

the provisions of this part.

(2) The local board of health of the county in which a violation of this part occurs may bring an action to enjoin a violation of any provision of this part."

Section 7. Section 50-40-109, MCA, is amended to read:

"50-40-109. Penalties. (1) A person proprietor, manager, or person in charge of an enclosed public place who knowingly fails to designate the entire enclosed public place as a nonsmoking area or reserve a smoking or nonsmoking area in his establishment as provided for in 50-40-104 is--guilty--of--a-misdemeanor-and-is-subject-to-a fine-of-not-more-than-$25, shall be fined an amount not to exceed $100. Each day that a violation continues constitutes a separate offense.

(2) A person who knowingly smokes in a part of an enclosed public space that is not designated as a smoking area under 50-40-104 shall be fined an amount not to exceed $50.

(3) Fines must be paid to the county treasurer of the county in which the enclosed public place is located or where the unauthorized smoking occurred."

NEW SECTION. Section 8. Inspections. An authorized representative of the local health officer or the department may inspect an enclosed public place during its working hours as often as necessary to determine compliance with the

provisions of this part.

NEW SECTION. Section 9. Repealer. Section 50-40-201, MCA, is repealed.

NEW SECTION. Section 10. Codification instruction. Section 8 is intended to be codified as an integral part of Title 50, chapter 40, and the provisions of Title 50, chapter 40, apply to section 8.

NEW SECTION. Section 11. Saving clause. This act does not affect rights and duties that matured, penalties that were incurred, or proceedings that were begun before the effective date of this act.

NEW SECTION. Section 12. Severability. If a part of this act is invalid, all valid parts that are severable from the invalid part remain in effect. If a part of this act is invalid in one or more of its applications, the part remains in effect in all valid applications that are severable from the invalid application.

-End-

and carried out by or under the direction of the state fire marshal of Montana. The state fire marshal is authorized to proceed to make such changes as may be necessary to standardize all existing fire protection equipment in this state immediately after March 1, 1929. He shall provide such appliances as are necessary for carrying on this work and shall proceed with such standardization as rapidly as possible and complete such work at the earliest date circumstances will permit.

History: En. Sec. 2, Ch. 53, L. 1929; re-en. Sec. 2762.2, R.C.M. 1935; R.C.M. 1947, 82-1234.

50-39-203. Notice of necessary changes — converting equipment. The state fire marshal shall notify industrial establishments and property owners having equipment for fire protection purposes which it may be necessary for a fire department to use in protecting the property or putting out fire of the changes necessary to bring their equipment up to the requirements of the standard hereby established and shall render them such assistance as may be available in converting their equipment to standard requirements.

History: En. Sec. 3, Ch. 53, L. 1929; re-en. 2762.3, R.C.M. 1935; R.C.M. 1947, 82-1235.

CHAPTER 40

SMOKING IN PUBLIC PLACES

Part 1 — Montana Clean Indoor Air Act

Section
50-40-101. Short title.
50-40-102. Purpose.
50-40-103. Definitions.
50-40-104. Designation or reservation of smoking or nonsmoking areas — notice.
50-40-105. No smoking signs in certain places.
50-40-106. Requirements of health care facilities.
50-40-107. Exemptions.
50-40-108. Enforcement.
50-40-109. Penalties.

Part 2 — Government Offices and Work Areas

50-40-201. Reservation of smoking and nonsmoking areas in work areas in state and local government buildings.

Part 1

Montana Clean Indoor Air Act

50-40-101. Short title. This part may be cited as the "Montana Clean Indoor Air Act of 1979".

History: En. Sec. 1, Ch. 368, L. 1979.

50-40-102. Purpose. The purpose of this part is to protect the health of nonsmokers in public places and to provide for reserved areas in some public places for those who choose to smoke.

History: En. Sec. 2, Ch. 368, L. 1979.

50-40-103. Definitions. As used in this part, the following definitions apply:

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

(2) "Enclosed public place" means 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, and assembly and meeting rooms open to the public.

(3) "Establishment" means an enterprise under one roof that serves the public and for which a single person, agency, corporation, or legal entity is responsible.

(4) "Person" means an individual, partnership, corporation, association, political subdivision, or other entity.

(5) "Smoking" or "to smoke" includes the act of lighting, smoking, or carrying a lighted cigar, cigarette, pipe, or any smokable product.

(6) "Smoking area" means a designated area in which smoking is permitted.

(7) "Place of work" means an enclosed room where more than one employee works.

History: En. Sec. 3, Ch. 368, L. 1979; amd. Sec. 1, Ch. 460, L. 1981.

Compiler's Comments

1981 Amendment: Added "open to the public" at the end of (2); inserted subsections (4) and (6); and substituted "Place of work" for "Working area" in (7).

50-40-104. Designation or reservation of smoking or nonsmoking areas — notice. (1) Except for those enclosed public places provided for in 50-40-105 and as provided in 50-40-201, the proprietor or manager of an enclosed public place shall:

(a) designate nonsmoking areas with easily readable signs; or

(b) reserve a part of the public place for nonsmokers and post easily readable signs designating a smoking area; or

(c) designate the entire area as a smoking area by posting a sign that is clearly visible to the public stating this designation.

(2) The proprietor or manager of an establishment containing enclosed public places shall post a sign in a conspicuous place at all public entrances to the establishment stating, in a manner that can be easily read and understood, whether or not areas within the establishment have been reserved for nonsmokers.

(3) The proprietor or manager of an establishment containing both a restaurant and a tavern, in which some patrons choose to eat their meals in the tavern, is not required by this part to post a sign described in subsection (2) in the tavern area of the establishment.

History: En. Sec. 4, Ch. 368, L. 1979; amd. Sec. 2, Ch. 460, L. 1981; amd. Sec. 2, Ch. 505, L. 1985.

Compiler's Comments

1985 Amendment: Near beginning of (1) inserted "and as provided in 50-40-201".

1981 Amendment: Added "by posting a sign that is clearly visible to the public stating this designation" at the end of (1)(c); and added subsection (3).

50-40-105. No smoking signs in certain places. No smoking signs shall be conspicuously posted in elevators, museums, galleries, kitchens, and libraries of any establishment doing business with the general public.

History: En. Sec. 5, Ch. 368, L. 1979.

50-40-106. Requirements of health care facilities. (1) Health care facilities shall:

(a) ask all in-patients, prior to admission, to designate their preference for a nonsmoking or smoking patient room and, when possible, accommodate such a preference;

(b) prohibit smoking in all kitchens, laboratories, and corridors;

(c) prohibit smoking in storage areas for supplies or materials and wherever flammable liquids, gases, or oxygen is stored or in use;

(d) provide a nonsmoking area in all waiting rooms;

(e) prohibit employees from smoking in patient rooms; and

(f) require visitors to obtain express approval from all patients in the patient room, or from the patients' physicians, prior to smoking.

(2) Nothing in this section shall prohibit a health care facility from banning smoking on all or a part of its premises.

(3) All areas of a health care facility not specifically referred to in this section may be considered smoking areas unless posted otherwise.

History: En. Sec. 6, Ch. 368, L. 1979.

50-40-107. Exemptions. The following shall be exempt from this part:

(1) restrooms;

(2) taverns or bars where meals are not served;

(3) vehicles or rooms seating six or fewer members of the public.

History: En. Sec. 7, Ch. 368, L. 1979.

50-40-108. Enforcement. The provisions of this part shall be supervised and enforced by the local boards of health under the direction of the department.

History: En. Sec. 8, Ch. 368, L. 1979.

50-40-109. Penalties. A person who fails to designate or reserve a smoking or nonsmoking area in his establishment as provided for in 50-40-104 is guilty of a misdemeanor and is subject to a fine of not more than $25.

History: En. Sec. 3, Ch. 460, L. 1981.

Part 2

Government Offices and Work Areas

50-40-201. Reservation of smoking and nonsmoking areas in work areas in state and local government buildings. In offices and work areas in buildings maintained by the state or a political subdivision thereof in which seven or more employees of the state or political subdivision are employed, the manager or person in charge of the work area shall arrange nonsmoking and smoking areas in a convenient area.

History: En. Sec. 1, Ch. 505, L. 1985.

CHAPTER 41

LAETRILE

Part 1 — General Provisions

Section

ACVA Systems—Client List

Company	Business	Location
Atlantic Companies	Insurance	New York, NY
American Automobile Association	Insurance	Falls Church, VA
American Consulate	Government	Hong Kong
nerican College of Cardiology	Medical School	Bethesda, MD
merican Hospital	Hospital	Windsor, UK
Atlantic Richfield Co.	Commerce	Los Angeles, CA
Architect of the Capitol	Government	Washington, DC
Axis Building Company	Property Development	Tokyo, Japan
Albert Einstein Medical Center	Hospital	Philadelphia, PA
Bank Brussels Lambert	Banking	Brussels, Belgium
Bank of America	Banking	Los Angeles, CA
Banque de Paris et de Pays Bas	Banking	Hong Kong
Barclays Bank	Banking	Hong Kong
Belgian Airport Authority	Airport	Brussels, Belgium
Bridgestone Tire Corporation	Rubber	Tokyo, Japan
Brotman Medical Center	Hospital	Los Angeles, CA
Brunel University	Education	Uxbridge, UK
British Telecom	Communications	London, UK
Cable and Wireless Company	Communications	Hong Kong
Capitol Hill Hospital	Hospital	Washington, DC
Cedars Sinai Medical Center	Hospital	Los Angeles, CA
Central Electricity Generating Board	Electrical Power	Selby, UK
Children's Hospital	Hospital	Philadelphia, PA
Children's Hospital of the King's Daughters	Hospital	Norfolk, VA
Children's Hospital & National Med. Center	Hospital	Washington, DC
Ciba Geigy Corporation	Chemicals	Greensboro, NC
CIGNA	Insurance	Philadelphia, PA
Chippenham Hospital	Hospital	Richmond, VA
Chiyoda Building and Maintenance	Property	Tokyo, Japan
Citibank Limited	Banking	London, UK
Corporate Farmer's Union Insurance	Insurance	Tokyo, Japan
Carrol County MD Health Dept.	Government	Maryland
Delmarva Power Company	Utilities	Wilmington, DE
Department of Health & Human Services	Government	Rockville, MD
EPE Industries	Industry	Fredericksburg, VA
First Industrial Bank	Banking	Los Angeles, CA
Federal Reserve Bank	Banking	Washington, DC
Federal Reserve Bank of Richmond	Banking	Richmond, VA
Fusion Systems Corporation	Industry	Rockville, MD
General Services Administration	Government	Washington, DC
General Accident Company	Insurance	Philadelphia, PA
GEICO (Government Employees Ins.)	Insurance	Washington, DC
General Foods Corporation	Food	Tokyo, Japan
Grindley's Bank	Banking	Hong Kong
George Washington University Hospital	Hospital	Washington, DC
Handel's Bank	Banking	Stockholm, Sweden
Heathrow Hotel	Hotel	London, UK
Hewlett Packard	Engineering	Singapore
Hong Kong Land	Property	Hong Kong
Hong Kong and Shanghai Bank	Banking	Hong Kong
Hong Kong Telephone Co.	Communications	Hong Kong
Howard University Hospital	Hospital	Washington, DC
Hahnemann Hospital	Hospital	Philadelphia, PA
Imperial Chemical Industries	Chemicals	Billingham, UK
Insurance North America	Insurance	Philadelphia, PA
Institute of Scientific Information	Education	Philadelphia, PA
Independent Life Insurance Co.	Insurance	Jacksonville, FL
Johns Hopkins Hospital	Hospital	Baltimore, MD
Johnson Willis Hospital	Hospital	Richmond, VA
Kai Tak Airport	Airport	Hong Kong
Komatsu Corporation	Commerce	Tokyo, Japan
Kyodo Real Estate	Property	Tokyo, Japan
Laboratories of the Government Chemist	Government	London, UK
Lehigh Valley Hospital	Hospital	Allentown, PA
Lee Memorial Hospital	Hospital	Ft. Myers, FL
Lloyds Bank	Banking	London, UK
Mass Transit Railways Corporation	Transportation	Hong Kong
Mitsubishi Bank	Banking	Tokyo, Japan
Mitsubishi Real Estate	Property	Tokyo, Japan
Mitsui Bank	Banking	Tokyo, Japan
Mobil Oil Company	Oil	London, UK
Middlesex Hospital	Hospital	New Brunswick, NJ
National Westminster Bank	Banking	London, UK
Navy Federal Credit Union	Insurance	Vienna, VA
NS&T Bank	Banking	Richmond, VA
Oliver T. Carr Company	Property Development	Washington, DC
Pennsylvania Academy of the Fine Arts	Art Gallery/ Museum	Philadelphia, PA
Philadelphia Art Museum	Art Gallery/ Museum	Philadelphia, PA
Philadelphia Savings Funds	Insurance	Philadelphia, PA
Pacific Mutual Life	Insurance	Los Angeles, CA
Pacific South West Realty	Property	Los Angeles, CA
Portsmouth Naval Hospital	Hospital	Portsmouth, VA
Peterborough Council	Government	Peterborough, UK
Prudential Insurance Company	Insurance	Bala Cynwyd, PA
Pullman Kellogg	Engineering	Wembley, UK
Princeton University	Education	Princeton, NJ
Public Health Administration	Government	Washington DC
Public Health Services	Government	Hyattsville, MD
Riverside Hospital	Hospital	Newport News, VA
Royal Hong Kong Jockey Club	Gambling	Hong Kong
Rogers and Wells	Attorneys	Washington, DC
Sanyo Pharmaceuticals	Drugs	Tokyo, Japan
Science Museum	Museum	London, UK
Scotland Yard	Government/ Police	London, UK
Scott Paper Company	Industrial	Philadelphia, PA
Schlesinger Company	Property	Clifton, NJ
Sheraton Hotel	Hotel	London, UK
Sidwell Friends School	Education	Washington, DC
Sime Darby Company	Commerce	Hong Kong
Singapore Telephone Company	Communications	Singapore
Sogetsu School	Education	Tokyo, Japan
Sovran Bank	Banking	Richmond, VA
Springfield High School	Education	Springfield, PA
Social Security Administration	Government	Baltimore, MD
South China Morning Post	Newspapers	Hong Kong
Southern California Edison	Utilities	Los Angeles, CA
Standard Chartered Bank	Banking	Hong Kong
St. Mary's Hospital	Hospital	Richmond, VA
St. Vincent's Medical Center	Hospital	Jacksonville, FL
St. Christopher's Hospital	Hospital	Philadelphia, PA
Texas Instruments	Engineering	Singapore
Tokyo University Hospital	Hospital	Tokyo, Japan
U.S. Coast Guard Building	Government	Washington, DC
United Virginia Bank	Banking	Richmond, VA
Washington Post	Newspapers	Washington, DC
Women's Hospital	Hospital	Tokyo, Japan
Whittaker Memorial Hospital	Hospital	Newport News, VA
Wilmington Trust Company	Financial	Wilmington, DE
Westwood Management Co.	Property Management	Bethesda, MD

ACVA Atlantic Incorporated
10378 B Democracy Lane
Fairfax, VA 22030
(703) 352-0102

EXHIBIT

EXHIBIT # 2
DATE
HB #

The Science of Environmental Tobacco Smoke

Recent press reports have conveyed the impression that there is an emerging consensus within the scientific community that exposure to environmental tobacco smoke ("ETS") can harm the nonsmoker's health. That impression has arisen most clearly in stories that appeared when the Surgeon General's Report on ETS was released in mid-December 1986 and when the National Academy of Sciences ("NAS") released its ETS report in November 1986. In fact, the press coverage of those reports has been, in many cases, quite misleading.

Antismoking activists typically make several health claims with respect to ETS. Specifically, they often claim that nonsmoker exposure to ETS has been shown (1) to be associated with decreased respiratory function in adults, (2) to induce asthmatic attacks in sensitive individuals, (3) to cause or contribute to cardiovascular disease and to be hazardous to patients with preexisting heart disease, (4) to increase the risk of lung cancer and (5) to affect the respiratory health of children. None of these claims can withstand analysis.

1. Respiratory Function in Adults

Both the 1986 Surgeon General and NAS reports reject the antismokers' claim that exposure to ETS has been shown to impair adult pulmonary function in any significant way. As summarized in the Surgeon General's Report:

> "The physiologic and clinical significance of the small changes in pulmonary function found in some studies of adults remains to be determined. The small magnitude of effect implies that a previously healthy individual would not develop chronic lung disease solely on the basis of involuntary tobacco smoke exposure in adult life." SG Report, p. 62.

The NAS Report is to the same effect. See NAS Report, p. 10.

2. Asthma

Both the 1986 Surgeon General's Report and the NAS Report conclude that the available scientific evidence is inadequate to permit a finding that exposure to ETS can induce asthmatic attacks in sensitive individuals. Both reports note that the studies completed to date involved artificial chambers, unrealistically high levels of smoke and inadequate control of psychological factors. As noted in the Surgeon General's Report:

> "Acute exposure in a chamber may not adequately represent exposure in the general environment. Biases in observation and in the selection of subjects and the subjects' own expectations may account for the widely divergent results. Studies of

> large numbers of individuals with measurement of the relevant parameters will be necessary to adequately address the effects of environmental tobacco smoke exposure on asthmatics." SG Report, p. 65.

The similar conclusion of the NAS Panel may be found at NAS Report, p. 10.

3. Cardiovascular and Heart Disease

The Surgeon General's Report and the NAS Report also are in agreement in concluding that exposure to ETS has not been shown to cause or contribute to cardiovascular disease or to be hazardous to patients with preexisting heart disease. The conclusion reached in the Surgeon General's Report is again illustrative:

> "Further studies on the relationship between involuntary smoking and cardiovascular disease are needed in order to determine whether involuntary smoking increases the risk of cardiovascular disease." SG Report, p. 107.

> "One study suggested that involuntary smoking aggravates angina pectoris. This study has been criticized because the end point, angina, was based on subjective evaluation, and because other factors such as stress were not controlled for. More important, the validity of Aronow's work has been questioned." SG Report, p. 106.

Accord NAS Report, p. 11.

4. Lung Cancer

The suggestion that exposure to ETS can cause lung cancer has been widely publicized. But review of the actual studies that have been conducted confirms that a link between ETS and lung cancer among nonsmokers has not been established.

The ETS/lung cancer claim is based almost entirely upon a total of thirteen epidemiologic studies from around the world -- a very small number. Only three of those thirteen studies found a consistent statistical association between exposure to ETS and lung cancer among nonsmokers. When the studies on United States population are added together, as the NAS did, there is no statistically significant relationship between ETS and lung cancer. Indeed, only if the large and much-criticized study by Hirayama in Japan is considered can one find a modest increase in lung cancer risk. And even that finding cannot be made unless one ignores the critical defects that numerous scientists have pointed to in the Hirayama study.

Also noteworthy is the fact that only two of the available studies have taken into account total exposure to ETS, rather than simply exposure in the home. Those are the studies by Koo in Hong Kong and the 1985 study by Garfinkel of the American Cancer Society. Both of those studies failed to find a statistically significant relationship between lung cancer and ETS on the basis of total ETS exposure. Yet, it is precisely such exposure -- involving public places and the workplace in addition to the home -- that is needed to support public and workplace smoking restrictions.

5. Children

The studies of ETS and children have focused on parental smoking at home. Some of the studies have found that the children (especially infants) of smoking parents have an increased risk of respiratory infections and a slight decrement in lung function. One possibility is that this is due to the effects of ETS on the infant. It is not, however, the only possibility. Others include cross infection from the parents or other environmental or socio-economic related factors. It should be noted, in addition, that the slight decrement in lung function reported in a few studies has not been shown to have any clinical significance. But an even more important point, so far as public policy is concerned, is that there are no data tending to show -- and no responsible scientist who would suggest -- that a child's exposure to smoking in public places would impair the child's health in any way.

* * * * *

In sum, when the scientific facts underlying recent ETS-related press reports are reviewed, the conclusion that emerges is the one reached by the scientific symposium in Vienna, Austria, which was organized by the American Health Foundation, Austrian Society for Occupational Medicine, Bavarian Society for Occupational and Social Medicine, and German Society for Occupational Medicine, in cooperation with the International Green Cross:

> "Should lawmakers wish to take legislative measures with regard to [ETS], they will, for the present, not be able to base their efforts on a demonstrated health hazard from [ETS]."

Respectfully submitted by
The Tobacco Institute

January 1, 1987

EXHIBIT 3
DATE
HB

Feb. 17th 1987

STATEMENT OF SIMON TURNER - HELENA, MONTANA

CONCERNING THE CONTRIBUTION OF ENVIRONMENTAL TOBACCO SMOKE TO INDOOR AIR POLLUTION

I represent ACVA Atlantic, Inc., a company that specializes in the study and assessment of indoor air pollution. ACVA is often called upon to investigate complaints and symptoms among workers that are initially attributed to the presence of ETS in the workplace. Since we incorporated in 1981 we have now studied in excess of 36 million square feet of buildings perhaps confirming us as the most experienced private company in this field. ACVA seeks to identify the causes of indoor air quality problems — the "sick building syndrome" — and to recommend remedial steps. Clients include major banks, insurance companies, property developers, hospitals, colleges and government agencies.

ACVA's primary finding — that environmental tobacco smoke seldom is the cause of the indoor air pollution problems found in commercial buildings — should be of interest to this committee. In fact, ACVA has found that the confounding variables presented by a number of potential contaminants prevent a quick analysis establishing a single source of contamination. We frequently investigate buildings on account of complaints from occupants with symptoms such as eye and nose irritation, fatigue, coughing, rhinitis, nausea, headaches, sore throats and general respiratory problems. It is frequently assumed by our clients that these symptoms are due to ETS. However, it is clear that identical symptoms may be found in individuals exposed to Formaldehyde, Carbon monoxide, Oxides of Nitrogen and Ozone. In addition similar symptoms are reported by those individuals with allergies to Aspergillus, Cladosporium, and Penicillium fungi, among others, as well as to miscellaneous bacterial aerosols. Identical symptoms also can be caused by exposure to household dusts, cotton fibers, fiberglass fragments etc. and an ever increasing and similar problem is encountered due to low relative humidities.

Due to their unreliability, ACVA, as a policy, refuses to rely upon or otherwise use the information generated by subjective building occupant questionnaires. Only upon careful investigation of the entire indoor environment and ventilation system of a building can we draw informed conclusions about the various causes of poor indoor air quality.

As a result, we have made it our business to perform precisely such investigations. We have determined high levels of environmental tobacco smoke to be the immediate cause of indoor air problems in only five (or four percent) of the 125 major buildings investigated by ACVA 1981 - 1985. This result has been corroborated. In a similar study of 203 buildings from 1978 to 1983, NIOSH found that only four of the buildings studied (two percent) had indoor air quality problems attributable to high concentrations of ETS. Significantly, in those few cases where high accumulations of ETS have been found, ACVA also has discovered an excess of fungi and bacteria in the HVAC system. These microorganisms usually are found to be the primary causes of the complaints and acute adverse health effects reported by building occupants.

We have also found that HVAC systems are often poorly designed and negligently maintained. Excessive dirt accumulations are common in ductwork, even in hospitals. Following the inspection of a number of buildings, hundreds of pounds of fungi, dust, and dirt have been removed from such ductwork. Dead birds, insects, rodent carcasses and feces and excess amounts of dust have been found in many buildings where employees have complained of eye irritation, headaches, fatigue, nausea, allergies, and general respiratory problems. In addition, ACVA often discovers that the fresh air dampers of a building's HVAC system have been closed completely in an effort to save energy.

Indeed, the complex of symptoms that I have mentioned — the "sick building syndrome" — may result primarily from energy conservation efforts to seal buildings and reduce the infiltration/exfiltration of air. Such efforts have reduced the natural infiltration of fresh air that previously existed in many buildings, exacerbating the often undiscovered problem of a poorly designed or maintained HVAC system.

In addition to tightening buildings and sealing windows, building managers have shut down air conditioning systems at night and on weekends in an effort to lower energy costs. When the air conditio ng is shut down in humid climates, condensation builds up and settles inside the ductwork. If dirt is present in damp ductwork, spores

and microbes can flourish, only to be spread throughout the building once the HVAC system is turned on the next morning. This often results in Monday morning complaints of building odors or building sickness that disappear during the week, only to recur the following Monday morning. To save more energy, automatic temperature controllers are used to cycle fans on and off during the day. Vibrations from the start-up of these fans can cause dirt and microbes trapped inside ductwork to be dislodged and carried into occupied areas.

Another energy conservation effort that may contribute to sick building syndrome is the recirculation of indoor air, at the expense of fresh outdoor air. This may be a deliberate policy or by the designers shortsightedness. This results in the continuous redistribution of infectious microbes, allergenic dusts and spores from office to office and floor to floor. In addition, the substitution of low cost, low efficiency filters to reduce pressure drops and save energy seriously reduces the efficiency of building filtration systems, and can lead to serious indoor air quality problems. Moreover, filters may be not only poor but poorly installed.

The reason environmental tobacco smoke often is blamed for the symptoms associated with "sick building syndrome" is obvious: environmental tobacco smoke often is the only visible indoor air pollutant. ACVA has determined, however, that the presence of high concentrations of tobacco smoke indicates the much more serious problem of poorly designed and improperly maintained ventilation systems.

Improper ventilation can sometimes be carried to extremes. During the last two years, the fresh air dampers were closed completely in over 35% of those buildings studied by ACVA. One misguided engineer actually had bricked up the fresh air vents to save energy. All of these buildings were operating with 100% recycled indoor air. The lack of an adequate fresh air supply, coupled with dangerously low ventilation rates, has led to hazardous ventilation conditions in many of the buildings evaluated by ACVA. Similarly, almost 50% of the investigations conducted by NIOSH from 1978-1983 attributed the indoor air quality problems to inadequate ventilation.

We are aware of many studies of pollution, including ETS studies published in the literature, when the investigator or the buildings "maintenance engineers" confirmed that the fresh air dampers were open and therefore they concluded that there was adequate ventilation. In the first instance many designs of buildings do not allow adequate fresh air make-up (5 cfm per person whereas 20 cfm is necessary to maintain carbon dioxide levels at or below 1,000 ppm - now a law in some countries). Secondly we have demonstrated how the air may be moving out of the building through the fresh air intakes and thirdly we find inside the ducts hidden blockages of the systems, reheat coils etc. that completely destroy the buildings ventilation efficiency.

Some additional examples of ACVA's findings with respect to specific buildings may help to illustrate the general points that I have attempted to make:

1. Employees of a major bank were complaining of headaches, nausea, and general respiratory problems. The problem was traced to ozone being generated from the buildings high efficiency electronic air cleaner!

2. In 1983, physicians at the Health and Human Services Parklawn Building in Rockville, Maryland asked ACVA to investigate complaints of poor air quality. ACVA discovered that low efficiency and poorly installed filters had permitted unfiltered air into office areas occupied by 5,000-7,000 employees. In addition, recycled air rates were higher than permitted by normal building codes, and excess fungal growth in the air handling system was discovered. Filters were upgraded, the air handling systems were cleaned, and steps were taken to assure an adequate supply of fresh air. Air quality then improved substantially and complaints were virtually eliminated.

3. Students at a medical college in Maryland were experiencing respiratory problems. ACVA's investigation revealed excessive accumulations of allergenic fungi emanating from the air conditioning ductwork.

4. In a major banks operations center, ACVA discovered that loose fiberglass insulation in the ceiling voids was being carried via VAV boxes in the voids back to the occupied area bypassing the filtration system. Low cost filters installed across the openings of the VAV units cured the problem.

5. ACVA investigated one hospital in which the operating room exhaust air ducts had become clogged from lint and textile fibers. These operating rooms should have received 20 air changes per hour, they were receiving none. The ductwork was cleaned and the problem was resolved. In the operating rooms of that hospital there had been history of excessive cross infections, we identified the fungal contaminant and traced its source to the air conditioning system serving the OR's, the fungus was inside the fan chamber, past the protective filters, spores from this fungus were carried unimpeded through the ducts into the OR's - unfortunately this is a common story.

6. ACVA recently completed one of the most relevant investigations conducted to date. A large bank requested ACVA to investigate complaints of excessive ETS in a two year old building. The building always had been plagued with sickness problems. Another company had conducted a study through the use of subjective occupant questionnaires. Following analysis of the questionnaires, the bank was advised by that company to ban smoking throughout the building. The bank then sought a second opinion from ACVA. ACVA discovered that the ventilation system was designed poorly with the absolute minimum of 5 cfm per person of fresh air on average.

Unfortunately the distribution of the air through the duct systems rationed most of the staff to 2 cfm even if the system was working to its maximum potential. Still worse we found that all the fresh air dampers were completely closed to save energy. Even if the fresh air had been permitted to enter, however, the system was so inadequate that there would have been no filtration of that fresh outside air. Further, the indoor air was being recycled through grossly inefficient filters. Excessive levels of fungi were found in the air in all the offices and throughout the ductwork, including Cladosporium species. That bank is now in the process of cleaning and disinfecting the ductwork, as well as increasing the ventilation and upgrading the filters. This was a classic case of ETS being made a scapegoat for general internal pollution.

I could go on, ACVA has experience in at least another 100 or so examples. Naturally there is no time for this so I will summarize our findings and close this presentation.

ACVA's investigations have established that a multitude of factors contribute to poor indoor air quality. The confounding problems associated with these factors make their analysis and subsequent resolution difficult. To concentrate upon one element of this matrix, environmental tobacco smoke, would be inefficient and dangerous. It would be naive to assume that the removal or control of ETS, the most visible indoor air pollutant, would solve the indoor air pollution problems found in "sick buildings." That approach ignores the many hidden sources of indoor contamination, and can lead — at least in the short run — to a false sense of security.

ACVA's work and experience, as well as evaluations conducted by NIOSH, indicate that indoor air quality can be improved significantly with appropriate maintenance of and attention to a properly designed HVAC system. Assuring the introduction of filtered outside air, maintaining effective filtration systems, monitoring indoor air quality regularly, cleaning and repairing ductwork, and improving the designs of ventilation systems are necessary steps for the achievement of acceptable indoor air quality.

High concentrations of environmental tobacco smoke are a symptom of the much more dangerous problem of poorly designed or maintained ventilation systems. Persistent indoor air quality complaints can be resolved only if building managers and operators are prepared to focus on those systems in an appropriate manner.

Without such positive action to deal with the whole spectrum of indoor pollution there is a grave danger of one potential irritant taking the blame for all others, in our experience there is usually a combination of factors. In practice any misguided attack on environmental tobacco smoke may actually eliminate the one tell-tale marker we now have that a ventilation system is inadequate.

Simon Turner.
ACVA Atlantic Inc. (2/17/87).

EXHIBIT # 14
DATE 2-17-89
HB # 675

MR CHAIRMAN-MEMBERS OF THE COMMITTEE
JIM DURKIN
LOBBYIST - GREAT FALLS
SMOKEETER OF MONTANA

I'M IN OPPOSITION TO HB 675--I FAVOR THE PRESENT LAW CREATING THE **MONTANA CLEAN AIR ACT.** THE BUSINESS COMMUNITY SHOULD BE COMMENDED FOR IT'S COMPLIANCE WITH THIS LAW. A GOOD EXAMPLE OF HOW WELL THE LAW WORKS IS ONLY 300 FT. FROM HERE. TO-DAY A VISITOR TO THE HOUSE GALLERY CAN ENJOY THE BEAUTIFUL VIEW OF THE MEMBERS ON THE FLOOR-THE SMOKE FILLED ROOM IS GONE.

DON'T MAKE IT MORE DIFFICULT FOR SMALL BUSINESSES TO STAY ALIVE IN MONTANA. WE ALREADY HAVE TO MANY RESTRICTIONS AND REGULATIONS ON THE BUSINESS COMMUNITY.

SMALL BUSINESSES NOT LARGE ENOUGH TO DESIGNATE BOTH SMOKING AND NON-SMOKING AREAS COULD BE FORCED OUT OF EXISTENCE BY THE PASSAGE OF HB 675.

I ASK YOU TO STAY WITH OUR PRESENT MONTANA CLEAN AIR ACT-IT IS WORKING.

I WILL LEAVE WITH YOU A COUPLE OF INSERTS USED IN NEW JERSEY AND NEW YORK LEGISLATION, WHICH HELPED THE SMALLER BUSINESS STAY ALIVE. WE CAN HAVE CLEAN AIR IN MONTANA WITH THE PROPER USE OF MODERN DAY ELECTRONIC AIR CLEANERS AND THE PROPER USE OF GOOD VENTILATION.

THANK YOU

EXHIBIT
DATE
HB

ABSTRACT OF LEGISLATION CONTAINING AIR CLEANER PROVISIONS

ASSEMBLY, No. 547, STATE OF NEW JERSEY. An Act Concerning Smoking in Restaurants and Supplementing Title 26 of the Revised Statutes.

". . . A Restaurant which provides a nonsmoking section shall post a sign no smaller than 8 inches by 5 inches stating that "This restaurant offers a non-smoking area." A restaurant which does not provide a nonsmoking section shall in the same manner post a sign stating that "This restaurant does not offer a nonsmoking area, as permitted by law." A restaurant which is equipped with air cleaners or air recirculating systems which meet the standards of the model code of the Building Officials and Code Administrators International, Inc., known as the "BOCA Basic National Building Code 1984," as administered by the State Department of Community Affairs shall in the same manner post a sign stating "Approved air-cleaning equipment is installed in place of a non-smoking area."

(NOTE: Copies of complete law are available from United Air Specialists, Inc.)

LOCAL LAW 1984-12, "A Local Law Limiting Smoking in the County of Suffolk," New York.

". . . (f) Smoking is prohibited in every publicly or privately owned coffee shop, cafeteria, short-order cafe, luncheonette, sandwich shop, soda fountain, restaurant, or other eating establishment serving food whose occupied capacity is more than fifty (50) persons excluding from that calculation of capacity any portion of such facility which is located outdoors and any portion of such facility which is utilized for bar purposes.

(i) This prohibition shall not apply to any such establishment maintaining a contiguous no-smoking area of not less than one-fifth (1/5) of both the seating capacity and the floor space in which customers are being served, excluding from said calculations any portion of such facility which is located outdoors and any portion of such facility which is utilized for bar purposes.

(ii) At the request of a patron, the patron shall be seated in a nonsmoking area if a seat is available.

(iii) This prohibition shall not apply to any rooms which are being used for eating establishment purposes for private functions, but only while any such room is used for such private functions.

(iv) This prohibition shall not apply to any such establishment which installs an acceptable air-cleaning system for each room in which customers are being served by said establishment."

(NOTE: Copies of complete ordinance are available from United Air Specialists, Inc.)

EXHIBIT #1
DATE
HB

WITNESS STATEMENT

NAME DAVID LACKMAN BILL NO. HB 675

ADDRESS 1400 Winne Avenue, Helena, MT 59601 443-3494 DATE 2/17/87

WHOM DO YOU REPRESENT? MONTANA PUBLIC HEALTH ASSOCIATION & AMERICAN P.H. ASSN.

SUPPORT XXX OPPOSE AMEND

PLEASE LEAVE PREPARED STATEMENT WITH SECRETARY. HB 675 (Miles) Revising and clarifying the clean indoor air act. Tuesday, 2/17, 12:30 , Room 312 D (Human Services)

Comments: Both of my associations have pledged to work towards a "non-smoking society in the United States by the year 2000. Today we are concerned with the effects of breathing ambient smoke from tobacco in enclosed places. As a medical scientist with a pathology minor, I have seen, in the course of examining histological slides from necropsies, great untoward changes in the walls of blood vessels. We know now that much of this is due to inhalation of tobacco smoke.

The first Surgeon General's report on the effects of smoking was issued by Luther Terry; a friend of mine from Public Health Service days, and a reformed smoker. Dr. Terry was a physician of unquestionable integrity. Later he moved to my alma mater as Vice-President for Medical affairs at the Univ. of Pennsylvania. There he eventually succumbed to the effects of cardiovascular disease; probably aggravated by his earlier smoking habits. Every Surgeon General since then has extended the studies on the effects of inhalation of tobacco smoke; and found them to be increasingly disastrous, to human health. The latest is Surgeon General Koop's warning about the effects of breathing ambient air contaminated with smoke from tobacco.

When I last appeared before this committee; a remark was made to the effect- why be concerned, medicare will pay. I have grandchildren and am concerned by the financial mess we are creating for them; especially the approaching fiscal crisis in Medicare and Medicaide. Smoking; and exposure to it, contributes much to medical costs.

THANK YOU

DBL

CS-34

EXHIBIT
DATE
SB

WITNESS STATEMENT

NAME _____ BILL NO. _____

ADDRESS _____ DATE _____

WHOM DO YOU REPRESENT? _____

SUPPORT _____ OPPOSE _____ AMEND _____

PLEASE LEAVE PREPARED STATEMENT WITH SECRETARY.

Comments:

Blue Cross
and
Blue Shield
of Montana

EXHIBIT A 15
DATE 2-11-87
HB 776
SUPPORT

Helena Division
404 Fuller Avenue • P.O. Box 4309
Helena, Montana 59604
(406) 444-8200

Great Falls Division
3360 10th Ave. South • P.O. Box 5004
Great Falls, Montana 59403
(406) 761-7310

Reply to Helena Division

February 4, 1987

M E M O R A N D U M

TO: All Employees

FROM: Alan Cain

SUBJECT: Smoking Policy

I want to thank all of you for your cooperation with Phase I of the Smoking Policy that we have instituted at Blue Cross and Blue Shield of Montana. Phase II will be effective February 16, 1987 (the conclusion of current smoking cessation classes). There will be no smoking allowed at the work stations and private offices, or in the hallways, bathrooms or meeting rooms at Blue Cross and Blue Shield of Montana. Smoking will be allowed in the cafeteria in Helena and the smoking lounge in Great Falls.

For those who wish to quit smoking all together, a self-instruction stop smoking video program - "In Control" - will be offered on an ongoing basis. Please let Human Resources know if you are interested in participating in this program.

The incentive program which rewards $100 for the first year and $50 for the second consecutive year will phase out after July, 1987, (i.e., you'll need to make your commitment to stop smoking before July).

It would also be helpful to not have ashtrays available on your desks, etc., so as to discourage visitors from smoking.

Please remember to include appropriate break times in your meeting agendas to allow smokers to go to the designated areas to smoke.

The last phase, which will be an opportunity to assess when and if a total smoke-free environment will take place, which would include the issue of hiring nonsmokers only, will be determined later this year.

Managers and supervisors have the responsibility to see that the spirit and intent of this policy is complied with and to enlist the cooperation of employees in accomplishing this objective, recognizing the needs and problems of both smokers and nonsmokers. Disputes will be handled through the standard disciplinary procedures, (i.e., first step - oral reprimand, second step - written reprimand, third step - suspension and/or termination).

EXHIBIT
DATE
HB

WITNESS STATEMENT

NAME Lloyd Linder 447-1734 BILL NO. HB635

ADDRESS 2 N Rodney Helena DATE 2/19/91

WHOM DO YOU REPRESENT? SELF (CITIZEN)

SUPPORT X OPPOSE _____ AMEND _____

PLEASE LEAVE PREPARED STATEMENT WITH SECRETARY.

Comments: I FEEL AS A NON SMOKERS WE ARE NOW IN THE MAJORITY WE HAVE A RIGHT TO REQUEST SMOKING AREAS BE SET UP OR SMOKING NOT BE ALLOWED! AS I FEEL MY AIRSPACE HAS BEEN INFRINGED UPON BY SMOKERS IF A PERSON CAME INTO A PUBLIC PLACE ESPECIALLY A RESTAURANT WITH OFFENSIVE ODORS ON THEM OF ANY KIND OR VOMITUS AND ODORS OF VOMITUS IN THIER CLOTHING THAT PERSON WOULD SURELY BE HELPED OUT OF THE BUSINESS, THEY WHY NOT THE STINK OF SMOKING

AS A LICENSED MORTICIAN FOR 26 YEARS I CAN ALSO SAY LUNG TISSUE OF PEOPLES HEALTH IS BADLY AFFECTED BY SMOKE AND I URGE YOU TO GIVE HB635 A DO PASS RECOMMENDATION!

Again, I want to thank you for your cooperation in instituting this program at Blue Cross and Blue Shield of Montana, as we are dedicated to providing a healthy, comfortable and productive work environment for our employees. This goal can only be achieved through ongoing efforts to prevent absenteeism and to help employees adjust to restrictions on smoking.

If you have any questions concerning the above, please see the Human Resources Department at your site.

tpd/0814s

Professional Building 510 - 1st Avenue North #4 Great Falls, Montana 59401 (406) 452-2362 (406) 452-1401
1-800-447-9442 In State

EXHIBIT # 20
DATE 2-17-87
HB # 675

American Heart Association

Montana Affiliate, Inc.

February 16, 1987

TO: HUMAN SERVICES AND AGING COMMITTEE MEMBERS
MONTANA STATE HOUSE OF REPRESENTATIVES
FROM: MADELYN L. MOORE, EXECUTIVE DIRECTOR
AMERICAN HEART ASSOCIATION, MONTANA AFFILIATE, INC.

SUBJECT: HB 675 - REVISING AND CLARIFYING THE MONTANA CLEAN INDOOR ACT
HEARING - TUESDAY, FEBRUARY 17, 1987
SPONSOR - JOAN MILES AND OTHERS

On behalf of the Montana Heart Association statewide cadre of volunteers and its board of directors, I urgently request your favorable consideration of HB 675.

Plus results of other tobacco products, cigarette smoking costs some $65 billion annually in health care, loss of economic productivity due to poor health and treatment of cigarette-related illness through Medicare and Medicaid programs. This $65 billion breaks down into $17.8 billion in healthcare; $43 billion in loss of economic productivity; and $4.2 billion in Medicare/Medicaid expenditures.

Smokers have more than twice the risk of heart attack as non-smokers - it therefore follows that sidestream smoke affects all non-smokers by introducing toxic substances to persons in the area. It is extremely important that individuals be protected from this hazard by having a clean air space available for their protection. Beyond health damage to all, it should be mandatory that infants, the very elderly, and those with pulmonary problems have available areas free of tobacco smoke.

One item of information from the Surgeon Generals 1986 report should be of outstanding significance in your decision concerning HB 675 - TAR---THE MOST CARCINOGENIC SUBSTANCE IN CIGARETTE SMOKE---IS 70% MORE CONCENTRATED IN SIDESTREAM SMOKE.

Your support of HB 675 would truly be an important step in making Montana a safe and healthy state for all. Thank you for your consideration.

EXHIBIT
DATE
SB

MONTANA CHAPTER

OF THE

AMERICAN PHYSICAL THERAPY ASSOCIATION

AN HISTORICAL PERSPECTIVE OF PHYSICAL THERAPY

Physical therapy emerged as a medical discipline following World War I. A formal program for physical rehabilitation was needed but none existed. As a result of a study of European programs for physical rehabilitation, the Division of Special Hospitals and Physical Reconstruction was established in August, 1917. Physicians developed Reconstruction Aides from physical educators and nurses to assist in rehabilitating the surviving patients with war-related injuries and disabilities from World War I.

In the early 1920's, the Reconstruction Aides organized to become the American Physiotherapy Association. These early physiotherapists, as they were known, were trained in hospitals for short periods of time to meet the needs of our country.

By the 1930's, the American Medical Association with the American Physiotherapy Association developed educational programs for physiotherapy in medical schools. As the success and reputation of physiotherapy grew, so too did its body of knowledge culminating by 1940 in certificate programs for individuals holding bachelor degrees in physical education or nursing.

During the 1940's and 50's, an Americanized designation to physical therapy from physiotherapy was made. Three significant forces (World War II, the Korean Conflict, and the polio epidemic) druing this time spurred the growth of the profession. Many victims of these travesties were kept alive with physical rehabilitation becoming an integral part of their existence.

In the late 50's and early 60's, physical therapy education evolved into baccalaureate degree programs, with an increasing number of states believing it appropriate to license the practitioners of physical therapy.

By the mid-60's, public policy recognized the physical therapy profession through inclusion in the Medicare and Medicaid legislation. The physical problems of senior citizens increased with the aging of the general population, necessitating an expansion of expertise in physical therapy.

From the mid-60's to the present, the expansion of skill, professionalism and knowledge through specialized research in physical therapy has continued. Greater amounts of work have been produced for physical therapists as the technology in medicine improves and extends lives. This has been evident in the polio epidemic survivors, in military conflict as in Vietnam, and most recently in total joint replacements and other innovative reconstruction procedures in the senior population.

By 1969, all fifty states licensed physical therapists. One year certificate programs have been phased out and replaced with four and six year degree granting university programs accredited by the American Physical Therapy Association. Advanced degrees at the Master's and Doctoral levels are held by many therapists. Specialization in the areas of orthopedics, pediatrics, cardiopulmonary, sports physical therapy and clinical electrophysiology is currently taking place with board certified specialists [illegible] annually as the strict criteria is met.

rehabilitation centers, school systems, private offices, industry and nursing homes. Our knowledge and expertise includes rehabilitative skills and preventive methods promoting health and wellness.

Because of the continuing professionalization and reputation of physical therapists, direct patient access is a logical step in allowing consumer choice in today's health care market. Eleven states and the U.S. Army have recognized this and have made physical therapy services directly accessible to the patient. We look for your support for direct patient access (SB31) to continue the advancing growth of the physical therapy profession in Montana.

Respectfully submitted,

Mary Mistal, P.T.
Vice-President of the Montana Chapter of
the American Physical Therapy Association

EXHIBIT
DATE
SB

Richard L. Gajdosik, Associate Professor
Physical Therapy Program
University of Montana

Richard L. Gajdosik 2/17/87

As a representative of the Professional Physical Therapy Program at the University of Montana, I would like to speak in support of Senate Bill 31. I have been on the faculty at the University for 10 years. I helped plan and implement the Program, which was first accredited by the American Physical Therapy Association in 1981, and is currently fully accredited. The Program was developed in response to both student needs and the health care needs of the State.

We seek to prepare physical therapists to deliver services primarily in a rural setting. so we select mature, highly qualified students. Their average age is 27 years, their average GPA is 3.5 (on a 4.0 scale), and as a group, their performance on the national professional licensing examination is among the highest in the nation.

Our goal is to produce independent thinking, competent practitioners. To achieve this goal we prepare students to evaluate neurological, musculoskeletal, and related cardiorespiratory functions, and to determine the appropriate physical therapy procedures to maintain or restore strength, range of joint motion, and improve functional levels. Our students complete courses in anatomy, physiology, neuroanatomy, pathology, physical therapy sciences, and medical sciences. They learn the signs and symptoms of both normal and abnormal functions of the body. We teach the students to perform complete evaluations before they implement a physical therapy program. They first collect subjective and objective information. Only after assessing this information do they develop a plan of treatment. They are instructed to recognize the limits of our scope of practice, and they learn to consult with other members of the health team when questions arise or when signs and symptoms are not consistent with those of expected movement dysfunctions. Through this education physical therapists are capable of autonomous practice in close cooperation with all members in the medical field.

The increasing number of scientific research publications documented in our professional journals demonstrates that we have accepted responsibility for generating our own body of knowledge; indeed the definition of a profession. The newest physical therapy procedures would be implemented more effectively by allowing patients direct access to physical therapists.

In summary, the quality of the students entering our program, as well as other programs throughout the country, and the direction they receive in their education, produces competent, independent thinking practitioners who work well in the medical community. I urge you to allow the public direct access to the expertise of physical therapists by voting to pass Senate Bill 31.

EXHIBIT
DATE
SB #51

Medical Associates, P.C.

A Professional Corporation
SEVEN EAST BEALL, BOZEMAN, MONTANA 59715
PHONE: 406-587-5123

Family Practice

Norman A. Fox, M.D.
DIPLOMATE, AMERICAN
BOARD OF FAMILY PRACTICE

John S. Patterson, M.D.
DIPLOMATE, AMERICAN
BOARD OF FAMILY PRACTICE

Robert J. Flaherty, M.D.
DIPLOMATE, AMERICAN
BOARD OF FAMILY PRACTICE

Leonard R. Ramsey, M.D.
DIPLOMATE, AMERICAN
BOARD OF FAMILY PRACTICE

Pediatrics

Paul H. Visscher, M.D.
DIPLOMATE, AMERICAN
BOARD OF PEDIATRICS

Eric Livers, M.D.
DIPLOMATE, AMERICAN
BOARD OF PEDIATRICS

James R. Feist, M.D.
DIPLOMATE, AMERICAN
BOARD OF PEDIATRICS

Todd D. Pearson, M.D.
DIPLOMATE, AMERICAN
BOARD OF PEDIATRICS

January 9, 1987

Senate Public Health Committee
Capitol Building
Helena, MT 59604

Dear Committee Members:

A bill before the Legislature would allow the public greater access to the services of Physical Therapists. Currently, the public has free access to the rudimentary physical therapy offered by Chiropractors, who lack training in traditional medical disciplines. Physical Therapists, on the other hand, are trained in and familiar with traditional medical concepts of physical therapy and could provide much more appropriate treatment for patients. If the case can be made for the public's free access to Chiropractic care, then there is no question that the public can clearly benefit from freer access to the care of registered Physical Therapists.

Sincerely,

R. J. Flaherty, M.D.

Robert J. Flaherty, M.D.

RJF:sw

EXHIBIT
DATE 2-17-87
SB 31

ORTHOPEDIC ASSOCIATES OF BOZEMAN, P.S.C.

206 NORTH GRAND
BOZEMAN, MONTANA 59715
PHONE 587-5546

E. LEE BLACKWOOD, M.D. FRANK W. HUMBERGER, M.D. BERNARD M. VARBERG, M.D.

January 15, 1987

Legislators of the 50th Session
State of Montana
Capitol Building
Helena, MT 59620

Dear Sirs:

After reviewing Senate Bill No. 31, an Act allowing direct patient access to physical therapy and amending Section 37-11-104, M.C.A., I wish to state that I am in favor of this bill allowing physical therapists to evaluate and initiate treatment of patients without the direct prescription of services by a physician. I feel that physical therapists in general are much better trained than chiropractors who have direct access to patient evaluation and care. It has been my experience that they use good judgment in their evaluation and treatment plans and are prompt in referral if they are concerned or have a problem. I feel good in giving my unqualified support for this bill and would encourage its passage.

Sincerely,

Frank W. Humberger, M.D.

FWH/mj

MONTANA CHAPTER

OF THE

AMERICAN PHYSICAL THERAPY ASSOCIATION

EXHIBIT # 15
DATE 2-17-87
BB # 31

To: House Human Services and Aging Committee

Re: Senate Bill 31, An Act Allowing Direct Patient Access to Physical Therapy

Understanding the benefits to the public that Senate Bill 31 can provide by allowing the public direct access to physical therapy, to a large part requires the understanding of the profession of physical therapy. What is physical therapy and what do physical therapists do?

First of all physical therapy is an integral part of the medical system. This is certainly demonstrated by our history and development over the last 68 years. Through this, the philosophy which guides physical therapy care has arisen out of medical and physical therapy research.

Physical therapy is not a new profession but rather one that is 68 years old. Through those years and as the profession has expanded physical therapists have provided a safe quality care to millions of patients. Our history indicates clearly that we have effectively treated patients and this bill will not change that particular aspect of physical therapy care. In actual practice, physical therapy care, as provided by licensed physical therapists, is done totally under the careful hands and decision making of the treating physical therapist.

Physical therapy is a profession that is rapidly expanding. Utilization is also rapidly increasing. The public, as well as other health care providers are realizing that for many patients, with a variety of problems and conditions, physical therapy provides a long term solution to their problem.

Physical therapists have considerable expertise in recognizing and treating limited bodily function resulting from musculoskeletal or neurological conditions. Physical therapy, and physical therapists, hold the philosophy of evaluating, treating, and educating patients to achieve optimum function as soon as possible. Perhaps most importantly physical therapists are able to expertly advise, and educate, individuals to understand their condition as well as how activities they do throughout the day working or recreating can effect the continued stress on the body that could result in prolonged injury. Physical therapy has an important preventive emphasis that in the long run can be very cost effective to consumers and third party payors.

Physical therapy is a team oriented profession. We are very cognizant of the skills of other professionals and will continue to work closely with those professionals with the primary goal of quality, effective patient care. Certainly core to that team approach is continued and on-going consultation with the patient's physician.

Physical therapy is a profession made up of individuals that share the same internal and external problems and concerns as other professions. We have a vast majority of individuals that work hard to advance the profession for better patient care and certainly in the present health care environment for cost effective care.

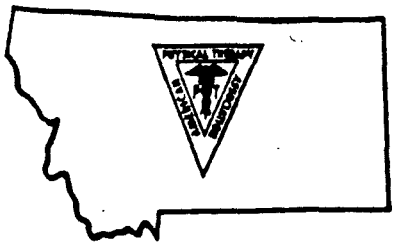
Senate Bill 31 allowing direct patient access to physical therapy will not change the scope of physical therapy practice in Montana. Physical therapists will continue to practice physical therapy only, a field that only physical therapists are best educated in. We know our profession well and we also know the boundaries that limit our profession. The long history of our referral and communication relationship will continue with physicians and other health care providers for quality patient care. For those individuals who choose to seek the services of a physical therapist initially to address their problems, Senate Bill 31 certainly provides them that right which could result in early intervention and safe and effective outcomes.

Physical therapy is a profession that can be trusted. It is a profession that has provided considerable benefit to the public for years and it is a profession that the public should have direct access to. I urge you to support Senate Bill 31 that will allow direct patient access to physical therapy.

Respectfully,

Gary Lusin

Gary Lusin



MONTANA CHAPTER

OF THE

AMERICAN PHYSICAL THERAPY ASSOCIATION

EXHIBIT #26
DATE 2-17-87
SB #31

February 17, 1987

RE: Senate Bill # 31
Clay Edwards, Physical Therapist

TO: Mr. Chairman and members of the House Human Services Committee

I want to briefly explain to you what I believe the passage of this Bill will do to the practice of physical therapy and what portion of the public will most benefit from the passage of this legislation.

During the two and one-half years that our state association has been drafting this legislation it has been, and still is, my personal belief that the practice of physical therapy will not change dramatically with the passage of this bill. We will continue to see 80-90% of our patients by means of physician referral. We will continue to have the very close working relationship we have always had with physicians.

The members of the public that will be dramatically and positively affected fall into several groups. There will be a major improvement in treatment for handicapped school children. Physical therapists are the only members of that treatment team that need a physicians referral. I personally have now waited 3½ months for a surgical report and doctors referral from a childrens hospital so I can legally and safely commence treatment for a student.

Another group that will benefit by cost and time savings by going directly to a physical therapist are those patients with chronic physical problems. Patients with arthritis, nonoperable neck and back pain, nonacute strokes and many other chronic disabilities will be able to get immediate treatment. In reality, many of these patients now go directly to the physical therapist and the referral is only a telephone call to the doctor from the therapist.

Injury prevention is rapidly becoming a major focus of business and industry. Physical therapists are ideally educated to present low back injury prevention seminars and are indeed doing so. These seminars have the potential of reducing workmens compensation claims and payments considerably. Am I currently breaking the law when I present these programs? Possibly. I certainly am when the inevitable employee remains to ask what they can do for their chronic low back problem. My statements to him are now treatment and are illegal. I believe

physical therapists are the most qualified persons in a community to present this information but we are about the only ones that cannot lawfully do it.

The last group that I want to single out is the public in general. There is now a major emphasis on wellness and health promotion in our society. Any physical education teacher, aerobics instructor, YMCA employee, or anyone else can open shop and instruct and counsel people on diet and exercise with almost no training. In most rural Montana cities and towns, the physical therapist or physician are the most qualified persons to present this information. The physician does not have the time and this antiquated referral requirement prevents me from doing it.

I urge you to give this bill a do pass recommendation from this committee. The referral requirement for physical therapy has outlived its need and is now preventing good medicine rather than promoting it.

Sincerely:

Clay Edwards

Clay Edwards, Physical Therapist
Dillon, Montana

EXHIBIT # 24
DATE
SB #

MAGINNIS AND ASSOCIATES

PROFESSIONAL INSURANCE ADMINISTRATORS

DONALD F. LANG
PRESIDENT

December 16, 1986

Mr. Gary Lusin
President
Montana Chapter
American Physical Therapy Association
c/o Bozeman Physical Therapy Center
300 North Willson
Bozeman, Montana 59715

Re: Practice Without Referral

Dear Mr. Lusin:

Our firm as a major administrator of Professional Liability insurance for physical therapists has been monitoring claims in those jurisdictions where practice without referral is allowed; specifically, Arizona, California, Maryland, Massachusetts, Nebraska, Nevada, North Carolina, Utah and West Virginia. It is my understanding that California and Nebraska are jurisdictions in which the therapist has been able to practice without referral for a considerable period of time. As of this writing, we have no firm evidence that practice without referral has had a negative impact on Professional Liability.

It would be normal, from an underwriter's approach, to expect that when the therapist is practicing independent of the physician, claim experience might be less favorable than that where a physician is involved. Again, we do not find this to be the case at the present time. I can only suggest to you that the professional therapist utilizes every viable tool available in order to provide the patient with the best care possible. I would also suggest that in those areas where practice without referral has been allowed, the truth of the matter is that the therapist counsels with the physician

Dear Mr. Lusin: December 16, 1986

in cases where there would be any questions whatever as to what might be proper in the handling of that patient. The less professional therapist is going to be more subject to losses with or without the restriction of requiring physical referral.

The number of incidents in the entire physical therapy area has been steadily increasing, as have been the dollar values of judgments in malpractice actions. These two factors in addition to others have had a negative effect on the pricing of Professional Liability coverage for physical therapists, but again that effect seems to be across-the-board and not a function of practicing with or without a referral. It is our intent to continue to monitor our therapy program. Should we notice any significant change in those areas where practice without referral is allowed, you may be assured that we will contact you personally.

Sincerely,

Donald F. Lang

DFL/cc
CC: Jerome Connolly
Physical Therapy Clinic

EXHIBIT #25
DATE 1-19-87
SB 31

KENNETH V. EDEN, M.D.

INTERNAL MEDICINE – GASTROENTEROLOGY

MEDICAL ARTS BLOCK
121 N. LAST CHANCE GULCH, SUITE G
HELENA, MONTANA 59601

TELEPHONE
(406) 442-1994

January 9, 1987

Members of Public Health Committee
State Senate
Helena, MT 59601

Dear Senators:

I would like to express my support for Senate Bill 31 regarding free access of patients to the care provided by Montana physical therapists.

In my own practice many patients are referred by me for evaluation by a physical therapist, and I have found them as a group to be well trained, conscientious and to render their services in a very professional manner.

In reality, many patients self refer to a physical therapists and then request authorization retrospectively. In almost all cases, I do this.

I think the present law in unrealistic and discriminates unfairly against physical therapists since patients have free access to others in the health care field such as chiropractors, acupuncturists, optometrists, naturopaths, and etc. Among these groups, I think the physical therapists are perhaps the most likely to refer patients whose problems are outside their area of expertise.

I think the risk of physical therapists failing to recognize a problem that is beyond their area of expertise is a real one but certainly no more so than it is for physicians or any other health professional. I think one must rely on professional integretity of which physical therapists as a group have demonstrated an ample amount.

Sincerely yours,

Kenneth V. Eden, M.D.

KVE/dr

EXHIBIT
DATE
SB

MONA JAMISON
ATTORNEY AT LAW

[illegible]
[illegible]
[illegible]
[illegible]

[illegible]

February 17, 1987

House Human Services and Aging Committee
Capitol Building
Helena, Montana 59604

RE: Senate Bill 31

Dear Chairman Gould and Committee Members:

For the record, I just wish to state that as the title and body of Senate Bill 31 indicate, there is nothing contained in either which directly or indirectly amends Section 33-22-111, MCA.

Sincerely,

Mona Jamison

Mona Jamison
Lobbyist
Montana Chapter of the
American Physical Therapy
Association

EXHIBIT 31
DATE 1
SB

Testimony - Senate Bill 31

Submitted by: Dr. Lee Hudson
Great Falls, Montana

February [illegible], 1987

Senators of this committee; good afternoon.
My name is Dr. Lee Hudson. I am a Board Eligible Chiropractic Orthopedist and a member of the Board of Directors for the Montana Chiropractic Association. I practice in Great Falls.

I would like to make it clear that we do not want to attempt to prohibit anyone from practicing the profession which they are trained for. The question at hand today is not whether the Physical Therapy profession is a worthy profession. It has a proven place in the health care community. The question we must ask today is whether the Physical Therapy profession has the education and training, most importantly in diagnosis, to become a portal of entry/primary health care provider. For the first and most important step in treating the human body is making a proper diagnosis. Only after a proper diagnosis has been made, can a treatment plan be formulated.

I have researched the similarities and differences in education between my profession (Chiropractic), and the Physical Therapy profession. I have not included the Medical profession in my research, however, Medicine and Chiropractic have comparable educational requirements.

I have obtained course curriculums from two major Physical Therapy programs, (Utah and Washington), and the curriculum of my Alma Mater (Northwestern College of Chiropractic).

1. Both Chiropractic and Physical Therapy require a minimum of two years pre-professional training.

2. Chiropractic profession training is a four year program. Physical Therapy professional training is a two year program.

3. The Physical Therapy programs researched were comprised of between 880 and 1,110 total hours of education. The Chiropractic program researched was comprised of 4,411 total hours of education. This is 4 times the total class hours.

PUBLIC BENEFIT OF DIRECT ACCESS

SCHOOLS

Direct access allows physical therapy treatment directly to handicapped school children and care at athletic events and sports programs.

BUSINESS AND INDUSTRY

Business and industry can effectively use physical therapy in reducing work-related injuries.

PUBLIC

General public can consult directly with physical therapists regarding wellness and fitness programs.

- Early intervention means early return to work and regular activities by decreasing the time between injury and treatment.
- Individuals with recurrent problems who benefit from physical therapy can seek physical therapy directly without delay.

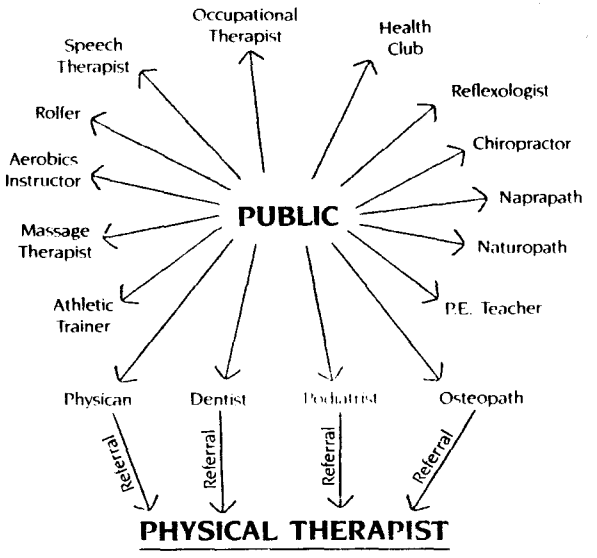
COST CONTAINMENT

Health promotion and wellness programs help contain spiraling costs of health care. In treatment, emphasis is given to educating patients in self-care and management of their condition, as well as preventing further injury.

SENIOR CITZENS

Seniors and their families can call upon a physical therapist directly to assist in raising the quality of life and level of independence.

CURRENT SITUATION



Of all these services available to the public, ONLY PHYSICAL THERAPY is under the referral requirement of another profession. This referral requirement limits patient access to the benefits of physical therapy.

PHYSICAL THERAPY EDUCATION

All physical therapists are graduates of accredited degree – granting university programs. Many therapists hold advanced degrees.

Strong academic and clinical course-work is progressively encountered to enhance evaluation and treatment planning skills.

Evaluation skills include the recognition of conditions, signs and symptoms that should be referred to another health care practitioner.

PUBLIC PROTECTION

Physical Therapists are licensed in all 50 state with state boards possessing investigative and disciplinary powers.

State law requires compliance with standard of practice of physical therapy.

State and national professional associations with judicial and disciplinary committees provide further measures for public protection.

Physical therapists will continue to work closely with hospitals, physicians and other health care practitioners to provide quality patient care.

The history of direct access to physical therapy in other states demonstrates no increased professional liability exposure or frequency of claim as a result of legislation allowing direct access

Last but probably most importantly;

4. Chiropractic education includes 1,260 classroom hours which are directly related to diagnosis. The Physical Therapy programs researched contain between 120 and 180 hours of courses which can be related to evaluation or diagnosis.

I would also like to point out that the education of a Physical Therapist contains 0 hours in x-ray diagnosis; a very valuable tool.

Chapter 26. THE GENERAL PHYSIOTHERAPY SUBMISSION

INTRODUCTORY

1. The New Zealand Society of Physiotherapists, in association with the New Zealand Manipulative Therapists' Association and the New Zealand Private Physiotherapists' Association, was represented at almost all hearings of the Commission. The submission of the society (Submission 75), including the material supplied in connection with it, was most useful to us. The society also helped to provide experts from overseas.

2. Although the conclusions reached by the New Zealand Society of Physiotherapists and its associated groups were not in favour of chiropractic, we should like to record that the stand taken was a constructive one. The physiotherapists saw themselves as critics of chiropractic, not enemies. It did seem, too, that some day all specialists in manual therapy, whatever their background, might be able to work together in further research. However, at present, physiotherapists are aligned with the Medical Association in opposing the provision of health benefits for chiropractic patients.

3. It was noteworthy that the group of physiotherapists specialising in manual therapy were responsible for preparing the material for the submission. They also presented it and were therefore available for cross-examination. This was valuable since, apart from the chiropractors, they were better informed on the use of manual therapy than any other group who appeared. Although, in general, they echoed the medical opposition, they were more specific and were also prepared to make suggestions about integrating chiropractic into the health system. They also saw the need for research into manual therapy.

EDUCATION OF PHYSIOTHERAPISTS

4. At this point something needs to be said about the education of physiotherapists and, in particular, of manipulative therapists since they maintain that they are capable of providing all the services now mainly performed by chiropractors.

5. A 3-year full-time course is offered for the Diploma of Physiotherapy. A third of the course (1200 hours minimum) is spent in clinical practice. The rest is made up of basic sciences, physiotherapy skills, clinical theory, and elective studies. Shorter than the chiropractic course, it is also much less demanding. Those who enter training in 1979 and in subsequent years will probably have a preregistration year after graduation.

6. The education of the physiotherapist at present is the education of a paramedical. He is taught the basic sciences as a general background to his role within the framework provided by the referring medical doctor. Obviously, once he is in practice, hospital or private, his skill and confidence grow. It is in rehabilitation of the patient that the work of the physiotherapist has special importance, particularly in the hospital setting. His main methods of treatment are electro-therapy, therapeutic movement (remedial exercise), traction, massage, and mobilisation procedures. Certainly physiotherapy education, with no significant

BACKGROUND

Physical Therapists have worked very closely with, and under the referral of physicans since 1918. The early physical therapists were trained in hospitals for short periods of time to meet our country's needs following World War I. Now physical therapists are graduates of accredited university programs. Many hold advanced degrees.

Since 1918, physical therapy has grown to a respected and valuable health care profession with a record of effectively treating millions of patients.

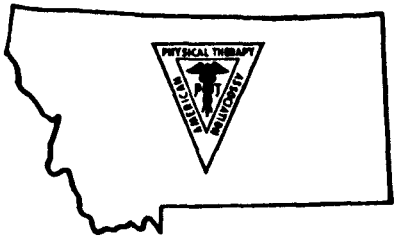
Today's physical therapists are well-qualified by both education and clinical experience to evaluate a patient's condition, assess the physical therapy needs, safely and effectively treat the patient, and refer the patient to other health care practitioners when indicated.

Referring practitioners generally rely on the professional judgement and expertise of physical therapists to devise the most effective treatment plan. Allowing direct access to physical therapy is consistent with this general practice.

Over the past several years Montanan's have become increasingly aware of the skill and reputation of physical therapists. Because of this, more and more people are requesting physical therapy services and many are frustrated to find they cannot go directly to a physical therapist for treatment.

Thank You

for Supporting
DIRECT PATIENT ACCESS
to
PHYSICAL THERAPY
in
MONTANA



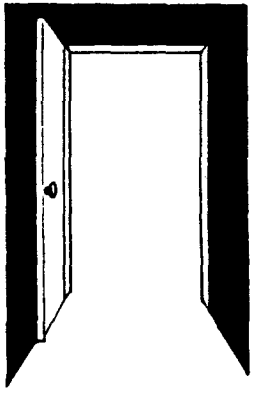
Dedicated to serving
Montana's health needs.

States allowing direct patient access to physical therapy include: Alaska, Arizona, California, Maryland, Massachusetts, Nebraska, Nevada, North Carolina, South Dakota, Utah, West Virginia.

Similar legislation is currently before 17 other legislatures.

EXHIBIT #30
DATE 2-17-87
SB #31

OPENING THE DOOR TO PHYSICAL THERAPY



AN ACT ALLOWING
DIRECT PATIENT ACCESS
TO
PHYSICAL THERAPY

Information from:
Montana Chapter
American Physical Therapy Association

President: Gary Lusin, M.S., A.T.C., P.T.
Bozeman, 587-4501

Legislative Chair: Mary Mistal, P.T.
Billings, 245-6513

Lobbyist: Mona Jamison, Attorney
Helena, 442-5581

EXHIBIT
DATE
SB

MONA JAMISON
ATTORNEY AT LAW

POWER BLOCK BUILDING, SUITE 4F
SIXTH & LAST CHANCE GULCH
POST OFFICE BOX 1698
HELENA, MONTANA 59624

(406) 442-5581

February 17, 1987

House Human Services and Aging Committee
Capitol Building
Helena, Montana 59604

RE: Senate Bill 31

Dear Chairman Gould and Committee Members:

For the record, I just wish to state that as the title and body of Senate Bill 31 indicate, there is nothing contained in either which directly or indirectly amends section 33-22-111, MCA.

Sincerely,

Mona Jamison

Mona Jamison
Lobbyist
Montana Chapter of the
American Physical Therapy
Association

n differential diagnosis, does not fit physiotherapists to be of primary health care. Moreover, we note that the staff of the apy schools are not highly qualified. Apart from part-time taff, very few have qualifications beyond the physiotherapy

TRAINING IN MANIPULATIVE THERAPY

come now to training in manipulative therapy, to use the term by the physiotherapists. This is defined by them to be movement beyond their normal passive range. The basics are taught early, in the last year is some limited instruction given in manipulation, the joints of the spine. Both in New Zealand and in England the n appeared to be elementary, even crude. At St. Thomas' in even under Miss J. Hickling who has so much influenced New therapists, the training appeared unstructured.

New Zealand, physiotherapists wishing to specialise in this field dertake the post-graduate course arranged by the New Zealand ative Therapists' Association. We have briefly discussed this in 5. The course reaches the standards of the International on of Orthopaedic Manipulative Therapy and there is no doubt ie New Zealand practitioners are highly skilled.

wever, the Commission has reservations about the way in which erapists as a group acquire their manipulative training. They are [illegible] and [illegible] are left to [illegible] trained. The sion has a similar reservation about those medical practitioners th even less training, in fact considerably less undertake spinal [illegible] We are satisfied that the greatest source of [illegible] in New Zealand is the chiropractor. he training of physiotherapists in areas other than manipulative makes them very valuable members of the health team. It would at they should concentrate their energies on promoting before ed medical men the benefits of physical therapy, and on improving [illegible] standards.

CRITICISM OF CHIROPRACTIC

[illegible] physiotherapists oppose chiropractic because they question the [illegible] training of chiropractors and the scientific basis for their theories as the way they shift their ground when trying to validate those s. However, as we discuss later (chapter 38), the chiropractors' attainment in the basic medical sciences clearly exceeds that of the therapist [illegible] approaches that of the medical graduate. We deal n chapter 37 with criticisms of the underlying scientific basis of ractic itself. As for the assertion that chiropractors "shift their l", we have touched on the point in chapter 8, para. 17. It is an ent that leads nowhere. It can support the view that chiropractors ltists: it can equally support the view that they have the open- d approach of the scientist.

Physiotherapists criticise the single modality of the chiropractor and ire it, to the latter's disadvantage, with their own range of ient. It is true that New Zealand chiropractors (though not arily North American ones) confine themselves to manual therapy as physiotherapists may utilise heat, light, ultra-sound, and water.

However, unless physiotherapists wish to encourage a duplication of effort, we see nothing objectionable in the chiropractor's choice of a single modality in which he specialises as long as he is fully informed of the value of physiotherapeutic methods and of the circumstances where they are indicated. An open attitude towards referral between chiropractors and physiotherapists is the best safeguard against any difficulty that might arise.

13. Manual therapy in the hands of physiotherapists, it is explained, provides treatment for the extremity joints, not just the spine. Their practitioners offer a total musculo-skeletal therapy, whereas, it is claimed, chiropractors are limited to the spine. We have already stated that current chiropractic courses provide adequate training in extremity joint procedures (see chapter 38). There is no legal impediment to chiropractors treating extremity joints, and many do.

14. Physiotherapists are convinced of the value of manipulation and argue strongly in its favour. However, they see no need for undue sophistication in this field. "It is our stance that manipulation, useful as it appears to be clinically should not be allowed to become shrouded in unnecessary sophistication which leads to overclaim inevitably and this is particularly so with regard to techniques" (Transcript, p. 1364). Clearly there are two distinct and strongly held points of view: that of the physiotherapist and that of the chiropractor.

15. The manipulative therapist learning his techniques as he does in a fragmented fashion, first very sketchily at a physiotherapy school, then in a course spread over 3 years or more in small sections, contends that while practice is essential there is little point in over-refinement of what is only a strictly limited range of techniques. The chiropractor, on the other hand, in his 4 or even 5 years at college has a much greater and more systematic exposure to techniques. He naturally believes that the expertise he achieves before he uses these techniques, unsupervised, on his patients, must with further practice give him a greater ability to help those patients. Besides, he tends to become a specialist in the one area, the spine.

16. It is claimed that chiropractors over-refine their skill. At the same time it is alleged that their technique consists mainly of the "dynamic thrust". This is claimed to be dangerous because it is a sudden high-velocity movement, the patient cannot see what is being done, cannot resist the thrust, and is therefore at the chiropractor's mercy. Until the Commission saw chiropractors at work it imagined from such descriptions that this was the only way the chiropractor operated while the physiotherapist/manipulative therapist with his gentle articulations, extensions, or mobilisations was a very different practitioner. The truth is that while the chiropractor's movements are indeed often very quick, perhaps more so than those of the manipulative therapist, they are also usually small and precise. The most forceful manipulations we saw were performed by manipulative therapists.

17. While the physiotherapists asserted that patients are often harmed by over-zealous manipulation by chiropractors, evidence in support was almost totally lacking and we find that chiropractic treatment is safe (see chapter 15). We have no evidence which would justify us in reaching any concluded view about the safety of spinal manual therapy carried out by practitioners other than chiropractors. It is astonishing how similar some of the perfected techniques are whoever the practitioners are. It is even more astonishing how unaware they are of this similarity. However, while there are a few physiotherapists and medical practitioners who are

especially skilled manipulators; all chiropractors have more training and experience (they are indeed full-time manipulators) and on average can be expected to be more skilled and more effective.

PHYSIOTHERAPISTS AND MEDICAL PRACTITIONERS

18. As we have said, the general physiotherapist submission largely supports the views of the Medical Association. However, particularly from the closing address of counsel for the Society of Physiotherapists (Submission 134), it became clear that physiotherapists, especially the manipulative therapists, face certain strains in their relationship with the medical profession, some of their own making, some caused by the medical attitude to other branches of the health services. Sections of the medical profession have adapted very well to a changing role, others have still to recognise that health care services no longer consist merely of doctors and nurses. Yet as the natural leaders of the team, medical doctors must help more to define their own role and that of others. All members need to become more aware of the skills of the others. Inter-disciplinary co-operation and interchange need to be developed, especially at a formal level.

GENERAL

19. Three useful points emerged from the submission itself. First the value of manual therapy performed by a trained and experienced practitioner, secondly, the continuing need for communication and co-operation among the different practitioners, and, thirdly, the need for more clinical research in manual therapy.

20. Whether the ordinary physiotherapist or even the manipulative therapist will want to extend his role to become a primary health care provider, as appears to be the desire in the United Kingdom, Canada, and Australia, will be a matter for the profession. If this is what it wishes, the training programmes would have to be considerably extended particularly in the area of diagnosis.

21. In the main submission and especially in counsel's closing statement, a plea was made for provision within the State-supported education system of high-level training in manual medicine. Certainly, as we have said, the future of the present manipulative therapists' training programme in New Zealand seems somewhat insecure: those organising it are unable to obtain Government funding for it. In the Commission's view this denial of Government funding could be justified on the ground that the manipulative therapy programme involves a duplication of the training in manipulative therapy conducted much more effectively in the chiropractic colleges. Certainly, nothing we have heard about the manipulative therapy programme convinces us that it can be compared in quality with the thorough full-time training over a period of years undergone by the chiropractor. In our opinion, if there is to be any question of Government funding for manipulative therapy education, it would be better allocated to bursary assistance to enable physiotherapists who wish to broaden their horizons to attend the Preston Institute in Melbourne. The Preston Institute, by the same token, might wish to consider whether the holder of a Diploma in Physiotherapy might receive some credits towards the chiropractic degree course.

22. In the Commission's view, the future of spinal manipulation, manual therapy, lies primarily with the chiropractic profession, but we should like to think, in close co-operation where necessary with the physiotherapists. We have more to say on this subject in chapter 45.

EXHIBIT 33
DATE
SB

CAPITAL CHIROPRACTIC CENTER

1732 PROSPECT AVENUE
HELENA, MONTANA 59601

GARY P. BLOM, D.C.
PHILIP A. BLOM, D.C., D.A.C.C.

(406) 449-7458

February 17th, 1987

The Montana Chiropractic Association believes that the physical therapists definitely are not qualified to diagnose or evaluate. Their education does not teach this and therefore they do not have the qualificaitons.

Many pathologies can mimic musculo-skeletal problems, therefore it is essential that a differential diagnosis be made. In addition to physical, neurological, and orthopedic testing, a radiographic examination should be utilized.

Physical therapists do not have the qualifications to perform or interpret x-rays. Many cancers, fractures, and other abnormalities are found through use of x-ray. These are various contraindications to using physiological theraputics such as heat, massage, ultra-sound, and mobilization especially if certain disease processes are present. These contraindications of treatment must be pointed out through precise diagnosing. We believe that this legislation is not in the best interest of public health.

P Blom

EXHIBIT 34
DATE 2-17-87
HB 31

MONTANA CHIROPRACTIC ASSOCIATION

TESTIMONY, SENATE BILL 31
SUBMITTED BY: BONNIE TIPPY
MONTANA CHIROPRACTIC ASSOCIATION
FEBRUARY 17, 1987

The major question raised by the proponents of this legislation is one of fairness. Is it fair that many types of health care providers can offer direct access to their patients while physical therapists cannot. But, I would like to point out to this committee that all of the other health care providers mentioned by the physical therapists are not licensed by the state of Montana. When this legislature chooses to license a profession, it is a major step. It is a "stamp of approval" on the practices of that profession, and a promise to the people of Montana that those people will be regulated and will only be allowed to practice within the scope of their education and their practice act.

Excepting acupunturists, who will be significantly impacted by legislation introduced this session, no other licensed health care providers in the state of Montana can provide direct services to patients with bachelors level training only. None. Not speech pathologists and audiologists, not psychologists, nurses, chiropractors, social workers or any other licensed professionals. What you would be doing with this bill is unprecedented.

You've heard testimony describing the lack of education of physical therapists and their inability to diagnose. By law they cannot take x-rays or do diagnosis. You have heard many promises today regarding diagnosis, that indeed, if a diagnosis is needed the physical therapists will refer the patients back to a medical doctor.

I would ask you this. How can any treatment be done before a diagnosis is made? This whole process seems rather backwards to me. If the physical therapists are going to do what they say, and indeed refer patients back to a medical doctor for diagnosis, then aren't we just adding a step to the whole process instead of eliminating one? I think that we need to be realistic. They will be doing diagnosis, and they don't have the educational background to do it.

Another issue is that of health insurance. It is true that this bill does not make health coverage of physical therapy mandatory. Most health insurance contracts cover for physical therapy treatments if those treatments are prescribed by a medical doctor. So, if a patient goes directly to a physical therapist for treatment, and they do have health

insurance, if that physical therapist is really doing his or her job, they will refer them straight back to a medical doctor for a prescription so that the services will be covered by health insurance. Once again, instead of eliminating a step in the process, we have added one. Or, perhaps the patient will remain unaware of his health coverage limitations and will receive the unhappy surprise of having to pay for the services himself.

We believe that the issue here is fairness, fairness to the consumers of Montana. If we are going to pass legislation such as this, I urge that an amendment be added to the bill which will require additional training and education in the area of diagnosis as a provision for direct access privileges. We have a rough draft of an amendment here, but we would like some more time to word it adequately. We have discovered that 28 universities and colleges throughout the United States offer master's degrees in Physical Therapy, and feel that at the very least, a master's degree should be required for these privileges. I am submitting a list of those Universities for your information. More education is certainly available.

I would ask that a subcommittee be formed in order to more carefully consider this legislation and possible amendments which would, indeed, make it a piece of legislation that is fair to everyone. With the crush of time that you are under right now prior to transmittal, we realize that your time needs to be spent acting on House bills. Since this is a Senate measure, there is a lot of time to give this matter adequate--and fair--consideration.

EXHIBIT #
DATE 2-17-81
SB #21

UNIVERSITIES OFFERING MASTERS DEGREES IN PHYSICAL THERAPY

University of Wisconsin, Maddison
University of Washington, Seattle
Old Dominion University, Virginia
University of Alabama, Birmingham
University of S. California
University of Florida
Unversity of Emery, Atlanta
Georgia State University
Medical College, Georgia
N.W. University Medical School, Chicago
University of Indianapolis
University of Iowa
University of Kentucky
University of Boston
Mass. General Hospital Institute of Health Professionals. Boston
N.E. University, Boston
University of Minnesota
Washington University School of Medicine, St. Louis
S. U. N. Y. Buffalo
Teachers College, Columbia N. York
Long Island University, Brooklyn
New York University
University of North Carolina
Ohio State University
Hahnennan University, Philadelphia
Temple University, Philadelphia
University of Pittsburg
Texas Womens University, Denton
Virginia College. Richmond.

EXHIBIT
DATE
SB

Good Morning:

My name is Stanley Rosenberg and I've come to speak in favor of Bill Number 31.

From 1965 to 1978, my employment with the Public Health service was either related to the hospital or long term care environment. In the early 70's, I was assigned by the Hill-Burton Program of the then HEW, to a Rehabilitation Hospital in Mass. I have had the opportunity to work with two Institutes of Physical Medicine, one in New Jersey (the Kessler Institute) and the Rusk institute in New York. I also have a chronic low back problem and utilize P.T. services about twice a year. Therefore, my experience with practicing physical therapists and physicians who order physical therapy is not insignificant. I speak to you now both as a person with some experience both as a health care provider and as a consumer.

By and large, most physicians I have encountered order physical therapy on a prescription blank with the words "P.T as indicated" or "P.T as required". In essence they are saying to the therapist, "You diagnose the problem, it's extent and provide the appropriate therapy."-- i.e., electric stimulation, massage, stretching, cold, heat etc, or any combination therof.

I said by and large, since the only physicians I've ever seen or worked with who specified treatment modalaties and areas of concentration were those who specialize in Physical Medicine, i.e., Physiatrists. I would suspect those who practice Sports Medicine do the same. But they too study Physical Medicine.

In essence then, going to a Family Physicians' office or an Internists office for a diagnosis and referral receive for their efforts a bill for the referral. Whereas if one went to the P.T and allowed them to make the determination of whether or not P.T. would be indicated, all insurance companies including medicare and medicaid as well as our own pockets would save money. The P.T. is trained to know what he or she doesn't know. They will and do refer to medicine those problems which require medical diagnosis and care.

In short, if I were required to see a physician every time I have a low back problem, I would wind up on the short end of the stick. I will need two referrals, one to the MD who will then refer me to the PT for "PT as needed", two trips, pay twice and keep the pain at least one extra day. In a sense, I'm fortunate to have a physician in Bozeman who allows me to call my Therapist for treatment. The therapist then asks for a prescription from the physician. Since they practice in the same building, and since my physician is enlightened, the system we have worked out satisfies all concerned.

I thank you for the opportunity to make this statement.

Stanley Rosenberg
4720 Itana Circle
Bozeman, MT 59715

EXHIBIT # 37
DATE 2-11-87
HB #675

Testimony Before the House Committee on Human Services and Aging

House Bill 675

(Requiring a Non-Smoking Area be Designated in Every Enclosed Public Place and Smoking be Prohibited in the Work Area of Non-Smokers' in Some Places of Work)

Mr. Chairman and members of the committee: I am Robert W. Moon, presenting in support of HB 675.

From a public health viewpoint, HB 675 represents an appropriate clarification to 50-40-104, the Montana Clean Indoor Air Act. Concerns over the health effects from passive cigarette smoke are hardly a myth, as some tobacco advertisements suggest. In reality, passive cigarette smoke is likely the most dangerous pollutant we face today.

The overwhelming body of scientific evidence shows that second hand smoke poses numerous health hazards to non-smokers. The 1986 Surgeon General's Report comes to three major conclusions:

1.) Involuntary smoking is a cause of disease, including lung cancer, in health non-smokers.

2.) Compared with children of non-smoking parents, children whose parents smoke have an increased frequency of respiratory distress and infection.

3.) Simple separation of smokers and non-smokers within the same air space may reduce, but does not eliminate environmental tobacco smoke (ETS).

Passive smoking does affect public health. New research shows that non-smokers are susceptible to smoke-related health problems. A review recently published by the National Academy of Sciences[2] states that approximately 20% of the estimated 12,200 lung cancer deaths occurring annually are attributable to ETS.

Experience with clean indoor air laws in other states indicates that posting of signs is the key to gaining compliance. However, the act was intended to promote the health of the public, rather than to support strict enforcement. Much of the success of the act will be measured by the non-smokers taking a firmer stand to protect the air they breathe. People should not be forced to breathe toxic chemicals against their will.

Hopefully, the 1987 Legislature will see the value of this clarification and fully support the measure.

References

1. Office of Smoking and Health. The Health Consequences of Involuntary Smoking: A Report of the Surgeon General, Rockville, Maryland: Public Health Service, 1986.

2. National Research Council, National Academy of Sciences. Environmental Tobacco Smoke: Measuring Exposures and Assessing Health Effects. Washington, D.C.: National Academy Press, 1986.

RWN/war-023b

EXHIBIT #
DATE
HB
Item #4, Dr. Koop's text.

Address

By

C. Everett Koop, M.D.

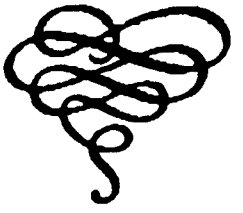
Surgeon General

U.S. Public Health Service

and

Deputy Assistant Secretary for Health

U.S. Department of Health and Human Services



Presented at the Workshop on Tobacco-Free Young America

Minneapolis, Minnesota

October 16, 1986

(GREETINGS TO HOSTS, GUESTS, FRIENDS, ETC.)

I AM DELIGHTED TO JOIN YOU THIS MORNING. AND I AM DOUBLY DELIGHTED TO SEE THE BROAD BASE OF SUPPORT FOR THIS WORKSHOP:

MY GOOD FRIENDS FROM THE LUNG AND HEART ASSOCIATIONS...

FROM THE CANCER SOCIETY...

FROM SCHOOL BOARDS AND SCHOOL ADMINISTRATIONS...

AND FROM THE PROFESSIONS OF MEDICINE, NURSING, AND PUBLIC HEALTH.

I'VE BEEN YOUR SURGEON GENERAL FOR 5 YEARS. AND FOR 5 YEARS I'VE BEEN ENGAGED IN THIS IMPORTANT CAMPAIGN TO REDUCE, IF NOT ELIMINATE ALTOGETHER, SMOKING FROM OUR SOCIETY.

THROUGHOUT THAT ENTIRE PERIOD I COULD NOT HAVE HAD BETTER ALLIES, CLOSER FRIENDS, OR MORE DEDICATED PARTNERS THAN THE THREE NATIONAL ORGANIZATIONS REPRESENTED HERE TODAY.

WITHOUT YOUR TOTAL COMMITMENT TO THE CAMPAIGN AGAINST CIGARETTES AND TOBACCO, THIS COUNTRY WOULD NEVER HAVE COME AS FAR AS IT HAS TOWARD THE GOAL OF A SMOKE-FREE SOCIETY BY THE YEAR 2000.

AND NOBODY KNOWS THIS BETTER THAN YOUR SURGEON GENERAL.

MINE IS A JOB THAT SOME FRIENDS IN TEXAS NOW AND THEN DESCRIBE AS "ALL HAT AND NO CATTLE." THAT MAY BE A LITTLE EXTREME...BUT I UNDERSTAND THEIR POINT.

THE FACT REMAINS, HOWEVER, THAT MY JOB WOULD BE MUCH MORE DIFFICULT -- IT WOULD BE IMPOSSIBLE -- WERE IT NOT FOR THE THOUSANDS OF CONCERNED AND DEDICATED CITIZENS WHO ARE ON MY SIDE.

AND TODAY, YOU AND I...TOGETHER...ARE ON THE SIDE OF YOUNG PEOPLE. I'M VERY ENCOURAGED BY THE PRESENCE HERE OF SO MANY INDIVIDUALS AND ORGANIZATIONS REPRESENTING THE NATION'S SCHOOLS. THOSE OF US IN THE HEALTH PROFESSIONS REALLY NEED YOUR HELP IN THE WORK THAT LIES AHEAD.

WE'RE SETTING OFF TO ACHIEVE A GOAL THAT'S VITAL FOR THE CONTINUED GOOD HEALTH OF OUR NATION:

WE WANT TO HELP YOUNG AMERICA BECOME "TOBACCO-FREE"
BY THE YEAR 2000.

AND WHAT'S THE SIGNIFICANCE OF THAT GOAL?

IF WE ACHIEVE IT, THAT MEANS...

WE WILL HAVE RESCUED THE YOUNG PEOPLE OF AMERICA
FROM THE PREVENTABLE BURDEN
OF SMOKING-RELATED ILLNESS AND DEATH.

PURE AND SIMPLE.

AND I WANT TO EMPHASIZE THOSE KEY WORDS -- "PREVENTABLE BURDEN OF SMOKING-RELATED ILLNESS AND DEATH" -- FOR TWO VERY GOOD REASONS:

FIRST, SMOKING IS A PERSONAL CHOICE, AS WE ALL KNOW. NO ONE IS REQUIRED TO SMOKE. ANYONE CAN -- AND, IN FACT, EVERYONE SHOULD -- CHOOSE NOT TO SMOKE AS HIS OR HER FIRST AND MOST IMPORTANT ACT OF PERSONAL PREVENTIVE HEALTH CARE.

AND SECOND, THE SCIENTIFIC RECORD IS CLEAR ON THE RELATIONSHIP BETWEEN CIGARETTE SMOKING AND ABOUT TWO DOZEN SERIOUS DISEASE CONDITIONS, MOST OF THEM WITH HIGH FATALITY RATES.

OVER THE PAST 30 YEARS BIOMEDICAL RESEARCHERS, PHYSICIANS, AND PUBLIC HEALTH PERSONNEL FROM MORE THAN 80 COUNTRIES HAVE GENERATED MORE THAN 50,000 STUDIES ON SMOKING AND HEALTH. ABOUT 2,000 MORE ARE ADDED EACH YEAR. IT'S AN EMBARRASSMENT OF RICHES.

THE OVERWHELMING MAJORITY OF THESE STUDIES CLEARLY IMPLICATE CIGARETTE SMOKING EITHER AS A CONTRIBUTING CAUSE OR AS THE PRIMARY CAUSE OF ILLNESS AND DEATH:

WE KNOW, FOR EXAMPLE, THAT A PERSON WHO SMOKES HAS A RISK OF SUDDEN CARDIAC DEATH THAT IS 3 TIMES THE RISK OF THE PERSON WHO DOES NOT SMOKE.

WE KNOW THAT ABOUT 85 PERCENT OF ALL LUNG CANCERS IN THE UNITED STATES ARE CAUSED BY CIGARETTE SMOKING. PEOPLE WHO SMOKE A COUPLE OF PACKS A DAY HAVE A LUNG CANCER DEATH RATE THAT IS AS MUCH AS 25 TIMES GREATER THAN THE RATE FOR PEOPLE WHO DON'T SMOKE AT ALL.

WE KNOW THAT CIGARETTE SMOKING IS THE MAJOR CAUSE OF CHRONIC OBSTRUCTIVE LUNG DISEASE, ESPECIALLY EMPHYSEMA AND CHRONIC BRONCHITIS. IN FACT, EMPHYSEMA IS QUITE COMMON AMONG OLDER PEOPLE WHO'VE SMOKED, BUT IT'S RARELY FOUND AMONG OLDER NON-SMOKERS.

AND WE KNOW THAT WOMEN WHO ARE PREGNANT HAVE AN INCREASED RISK OF DELIVERING THEIR BABIES PREMATURELY...OR OF ABORTING THE FETUS SPONTANEOUSLY...OR OF DELIVERING A STILLBORN CHILD...OR OF GIVING BIRTH TO A CHILD WHO IS UNABLE TO SURVIVE MORE THAN A FEW DAYS OUTSIDE THE WOMB.

THOSE ARE FACTS. THEY ARE PART OF THE INDICTMENT OF CIGARETTES WRITTEN BY MEDICAL RESEARCHERS HERE AND AROUND THE WORLD OVER THE PAST THREE DECADES. AND THE VERDICT IS IN:

SMOKING IS GUILTY OF BEING THE LEADING PREVENTABLE CAUSE
OF DISEASE AND DEATH IN THIS COUNTRY.

THAT'S THE VERDICT OF SCIENCE...BUT NOT ONLY OF SCIENCE. IT'S ALSO THE VERDICT OF OUR GOVERNMENT.

YOU KNOW THAT. FOR 20 YEARS, CIGARETTE PACKAGES AND ALL CIGARETTE ADVERTISING CARRIED THE LITTLE BOXED WARNING SAYING:

"THE SURGEON GENERAL HAS DETERMINED THAT
SMOKING IS DANGEROUS TO YOUR HEALTH."

THAT LABEL WAS ONE RESULT OF THE FIRST "SURGEON GENERAL'S REPORT ON SMOKING AND HEALTH," RELEASED IN 1964 BY THEN-SURGEON GENERAL LUTHER L. TERRY.

BY THE TIME I BECAME SURGEON GENERAL IN 1981, ANOTHER DOZEN REPORTS HAD BEEN RELEASED BY THREE MORE SURGEONS GENERAL: DRS. WILLIAM STEWART, JESSE STEINFELD, AND JULIUS RICHMOND.

THE SCIENTIFIC CASE AGAINST CIGARETTES WAS BY THEN AIR-TIGHT.

NEVERTHELESS, SINCE 1981 WE'VE PRODUCED 4 MORE REPORTS. THEY HAVE DOCUMENTED THE RELATIONSHIP BETWEEN...

SMOKING AND CANCER...

SMOKING AND CARDIOVASCULAR DISEASE...

SMOKING AND LUNG DISEASE...

AND -- THE MOST RECENT ONE -- ON SMOKING, CANCER, AND CHRONIC LUNG DISEASE AMONG WORKING PEOPLE.

THE CONCLUSION OF EACH REPORT HAS BEEN UNEQUIVOCAL: SMOKING IS A MAJOR CONTRIBUTOR TO THE INCIDENCE OF THESE DISEASES AND IS ALSO A MAJOR REASON WHY PEOPLE DIE FROM THESE DISEASES.

AND I MIGHT ADD THAT THIS PROCESS OF RESEARCH AND PUBLIC EDUCATION HAS CONTINUED THROUGH 5 PRESIDENTS, TWO DEMOCRATS AND THREE REPUBLICANS...THROUGH 10 SESSIONS OF THE UNITED STATES CONGRESS... AND RIGHT THROUGH GRAMM-RUDMAN-HOLLINGS.

AND NOW, FOLLOWING THE MOST RECENT LAW PASSED BY THE CONGRESS AND SIGNED BY PRESIDENT REAGAN, THE "COMPREHENSIVE SMOKING EDUCATION ACT OF 1984," THE MANUFACTURERS OF CIGARETTES MUST PUT NEW AND STRONGER WARNINGS ON THEIR PACKAGES AND IN ALL THEIR ADVERTISING.

THERE ARE 4 VERSIONS AND THEY MUST BE ROTATED EVERY 3 MONTHS.

THERE'S NOTHING FANCY ABOUT THESE WARNINGS. AND THERE'S NOTHING VAGUE ABOUT THEM EITHER. THEY CAN BE UNDERSTOOD BY ANYONE OF JUNIOR HIGH SCHOOL AGE AND ABOVE.

- ONE CATEGORICALLY SAYS THAT "...SMOKING CAUSES LUNG CANCER, HEART DISEASE, EMPHYSEMA, AND MAY COMPLICATE PREGNANCY."

- ANOTHER WARNS THAT "...PREGNANT WOMEN WHO SMOKE RISK FETAL INJURY AND PREMATURE BIRTH."

- A THIRD SAYS THAT "...CIGARETTE SMOKE CONTAINS CARBON MONOXIDE."

- THE FOURTH WARNING SAYS THAT "...QUITTING SMOKING NOW GREATLY REDUCES SERIOUS HEALTH RISKS." IN OTHER WORDS, IT'S NEVER TOO LATE TO QUIT. BUT QUITTING IS NOT EASY TO DO -- I KNOW THAT -- BECAUSE SMOKERS ARE ADDICTED TO NICOTINE, WHICH IS <u>THE MOST ADDICTIVE DRUG IN OUR SOCIETY</u>.

I WOULD LIKE TO SEE THESE FOUR MESSAGES BECOME REQUIRED READING IN EVERY CLASSROOM IN AMERICA. IT'S GOOD ENGLISH...IT'S GOOD SOCIAL STUDIES...AND IT'S VERY GOOD SCIENCE.

THAT, BRIEFLY, IS THE CASE OF THE PEOPLE AGAINST TOBACCO. AND, AS I SAID BEFORE, IT'S AIR-TIGHT.

BUT YOU SHOULD UNDERSTAND THAT THE CASE DEALS MAINLY WITH THE HEALTH RISKS OF <u>PEOPLE WHO SMOKE</u>, THE SO-CALLED <u>MAINSTREAM</u> SMOKERS WHO INHALE SMOKE DIRECTLY FROM THE CIGARETTE.

HOWEVER, BEHIND THE CLOUD OF MAINSTREAM SMOKE IS NO SILVER LINING BUT ANOTHER CLOUD...AND IT'S KNOWN AS SIDESTREAM SMOKE. THE CIGARETTE SMOKE THAT NON-SMOKERS INHALE INVOLUNTARILY FROM THE AMBIENT AIR.

RESEARCH IN SIDESTREAM SMOKE HAS EVOLVED SLOWLY BUT STEADILY OVER THE PAST 10 YEARS SO THAT, BY NOW, WE HAVE A PRETTY GOOD IDEA OF ITS EFFECTS.

ITEM: WE NOW KNOW THAT THE CHILDREN OF PARENTS WHO SMOKE HAVE A MUCH HIGHER RATE OF COLDS AND OTHER UPPER RESPIRATORY INFECTIONS, COMPARED TO CHILDREN WHOSE PARENTS DO NOT SMOKE.

SECOND ITEM: THE NONSMOKING WIFE OF A SMOKER RUNS A HIGHER RISK OF LUNG CANCER THAN DO THE NONSMOKING WIVES OF NONSMOKERS. BEFORE LONG, WE EXPECT TO HAVE CLEAR EVIDENCE THAT THE SAME IS ALSO TRUE FOR THE INCIDENCE OF HEART DISEASE, EMPHYSEMA, AND CONGESTIVE LUNG DISEASES AMONG NONSMOKING WIVES OF SMOKERS.

THIRD ITEM: "SIDESTREAM" SMOKERS EXPOSED TO OTHER PEOPLES' HEAVY SMOKING IN THE SAME OFFICE SPACE OR WORKROOM ABSORB AS MUCH SMOKE AS IF THEY THEMSELVES WERE "MAINSTREAM" SMOKING TWO OR THREE CIGARETTES PER DAY.

AND SO ON. THE NEXT SURGEON GENERAL'S REPORT ON SMOKING AND HEALTH WILL LAY OUT THESE AND MANY OTHER PIECES OF EVIDENCE CONCERNING THE DANGERS OF SIDESTREAM SMOKING.

NOW, JUST WHAT IS IT IN CIGARETTE SMOKE THAT IS SO HARMFUL FOR EVERYONE...WHETHER YOU'RE A "SIDESTREAM" OR A "MAINSTREAM" SMOKER?

FIRST OF ALL, YOU BOTH BREATHE IN THE SAME 4,000 OR SO CONSTITUENTS OF CIGARETTE SMOKE. YOU BOTH INHALE THE SAME TARS, THE SAME NAPTHALENE, AND THE SAME PYRENE AND BENZOPYRENE.

YOU ABSORB THE SAME CARBON MONOXIDE, METHANE, AMMONIA, AND ACETYLENE.

AND YOU INHALE THE SAME HYDROGEN CYANIDE.

ODDLY ENOUGH, SCIENTISTS HAVE DISCOVERED THAT SOME OF THESE TOXIC AGENTS ARE FOUND IN GREATER CONCENTRATIONS IN SIDESTREAM SMOKE THAN IN MAINSTREAM SMOKE:

o TAR, FOR EXAMPLE, THE SUBSTANCE THAT IS THE MOST CARCINOGENIC, IS 70 PERCENT MORE CONCENTRATED IN SIDESTREAM SMOKE THAN IN MAINSTREAM SMOKE...

o CONCENTRATIONS OF CARBON MONOXIDE ARE TWO AND A HALF TIMES GREATER IN SIDESTREAM SMOKE THAN IN MAINSTREAM SMOKE...

o NICOTINE IS 2.7 TIMES GREATER IN SIDESTREAM SMOKE...

o AMMONIA IS 73 TIMES GREATER IN SIDESTREAM SMOKE...AND SO ON.

THIS OUGHT TO BE ALARMING NEWS FOR TWO-THIRDS OF THE AMERICAN POPULATION...THE PEOPLE WHO DO NOT NOW SMOKE...OR, LET'S SAY, THE PEOPLE WHO THINK THEY DO NOT NOW SMOKE.

THEY MAY HAVE SAVED THEMSELVES FROM THE "STINK" AND THE "MESS" OF SMOKING...BUT THEY HAVE NOT COMPLETELY PROTECTED THEMSELVES FROM ALL THE HEALTH HAZARDS OF SMOKING. THOSE HAZARDS, WE HAVE DISCOVERED, ARE IN THAT AMBIENT AIR WE SHARE WITH SMOKERS.

I THINK THIS IS VERY POWERFUL INFORMATION THAT YOUNG PEOPLE IN THIS COUNTRY WILL WANT TO KNOW.

YOUNG PEOPLE DON'T LIKE BEING FOOLED...

THEY RESENT BEING MADE TO LOOK FOOLISH...

THEY HATE TO BE EXPLOITED...

AND IF THEY'RE GOING TO BE MESSY, THEY WANT TO DO IT THEMSELVES. THEY DON'T WANT ANYONE ELSE DOING IT FOR THEM, ESPECIALLY WITHOUT THEIR KNOWLEDGE OR CONSENT.

WE'VE GOT TO REACH THE YOUNG PEOPLE OF AMERICA WITH THIS NEW INFORMATION ON SIDESTREAM SMOKE -- IN ADDITION TO WHAT WE ALREADY KNOW ABOUT MAINSTREAM SMOKING. THEY HAVE A RIGHT TO KNOW THIS INFORMATION. AND I THINK IT WILL IMPRESS THEM VERY MUCH.

BUT DOING THAT INFORMATION AND EDUCATION JOB IS NOT THE PROVERBIAL "PIECE OF CAKE." YOU AND I KNOW THAT THE CIGARETTE INDUSTRY IS A VERY FORMIDABLE ADVERSARY.

THE CIGARETTE INDUSTRY ACCOUNTS FOR ABOUT 2.5 PERCENT OF THE NATION'S GROSS NATIONAL PRODUCT, OR ABOUT $60 BILLION. IT SPENDS ABOUT $2 BILLION A YEAR JUST ON ADVERTISING. THAT'S A LITTLE OVER $8 FOR EVERY PERSON IN THE UNITED STATES...SMOKER AND NONSMOKER ALIKE.

BUT, DESPITE THE BILLIONS OF DOLLARS THAT IT SPENDS, THE CIGARETTE INDUSTRY'S DAYS ARE NUMBERED. AND DESPITE THE MERGERS AND BUY-OUTS INVOLVING FOOD COMPANIES, THE CIGARETTE INDUSTRY IS NOT -- AND WILL NEVER AGAIN BE -- A GROWTH INDUSTRY.

YES, IT IS A FORMIDABLE ADVERSARY TODAY. BUT IT BECOMES LESS AND LESS FORMIDABLE WITH EVERY TOMORROW. FOR ALL ITS ENORMOUS ECONOMIC POWER, THE AMERICAN CIGARETTE INDUSTRY IS GOING TO DISAPPEAR OVER THE NEXT 20 YEARS. PER CAPITA CONSUMPTION IS DECLINING AND IT WILL NEVER AGAIN BE GOING UP. WE KNOW THAT...AND THEY DO, TOO.

HISTORY IS CLEARLY ON THE SIDE OF THE NONSMOKER ...ESPECIALLY THE YOUNG NONSMOKER. AND I BELIEVE THAT WE'VE SET OUT AN EMINENTLY ACHIEVEABLE GOAL, WHICH IS TO MAKE OUR YOUNG PEOPLE TOBACCO-FREE AND OUR COUNTRY SMOKE-FREE BY THE YEAR 2000. IT IS NOT AN IMPOSSIBLE DREAM.

I CAN ASSURE YOU THAT THE PUBLIC HEALTH SERVICE AND ITS SURGEON GENERAL -- I AND WHOEVER ELSE FOLLOWS ME -- WILL DO WHATEVER WE CAN TO MAKE THAT DREAM COME TRUE.

AND, LADIES AND GENTLEMEN...TOGETHER...WE JUST CAN'T MISS.

THANK YOU.

# # # # #

EXHIBIT 7
DATE 2-17-87
HB 675

(This sheet to be used by those testifying on a bill.)

NAME: Thomas W. Maddox DATE: February 17, 1987

ADDRESS: 1777 LeGrande Cannon Blvd., P.O. Box 123
Helena MT 59624-0123

PHONE: (406) 442-1582

REPRESENTING WHOM? Montana Association of Tobacco and Candy Distributors, a nonprofit corporation

APPEARING ON WHICH PROPOSAL: HB 675

DO YOU: SUPPORT? _____ AMEND? _____ OPPOSE? ✓

COMMENT:

PLEASE LEAVE ANY PREPARED STATEMENTS WITH THE COMMITTEE SECRETARY.

HB675 is a classic case of legislative overkill. Consider the history and the trend of smoking and of efforts to legislate ever greater tax on the product and at the same time restrict its use.

The legislative subject itself was first introduced in 1973. Since 1973 there has been a long history in public policy development; especially in areas where the legislature decided very specifically not to pursue. Over the years many legislatures have closely studied the smoking issue. Legislation has been enacted, moderated and modified in recognition of the need for flexibility in this area. We have opposed all of these bills because our members believe strongly that voluntarily adopted smoking policies, tailored to the needs of individual businesses, are preferable to even most flexible government mandate.

In the years since the first laws to restrict smoking, it is clear from the statistics — from casual daily observation — that cigarette smoking has declined drastically. We read and hear about the trend in our media. Read the recent news storyincluded with this presentation, headed, "Total cigarette consumption is falling". Look further to the Montana Department of Revenue chart in this testimony and it shows that cigarette smoking is falling to a lower level than the beginning of two decades ago. Montana cigarette tax revenues have fallen dramatically, reflecting a trend of Montana cigarette smoking even greater than the national trend.

Balance the facts that show cigarette smoking is substantially lower against yet to be proved assumptions that second-hand smoke is harmful. We accept that others' smoke may be annoying to some nonsmokers. We cannot accept that current trends and evidence demonstrates any problem of such scope as to justify so radical a proposal as HB 675.

Total cigarette consumption is falling

[illegible] (AP) — A law to balance the [illegible] would ban cigarette smoking [illegible] to prevent from [illegible] to fall and then fell [illegible] percent from that to [illegible].

[illegible] report said that total [illegible] "The remainder of [illegible] health con[illegible] restrictions.

An example of law restrictions is the government's ban on smoking in cigarettes, pipes and cigars in federal buildings except in designated areas, effective Feb. 6, 1987.

"The new regulations will reverse existing policy which permits smoking except where 'no smoking' signs are posted," the report said. "Federal building entrances will have signs reading, 'No Smoking Except in Designated Areas.' However, Government agencies will have wide latitude in setting table smoking areas."

According to the analysis, which is part of a forthcoming outlook report on the tobacco situation, cigar and smoking tobacco uses have also dropped steadily since 1970 and are expected to decline further through the remainder of the 1980s.

The use of snuff gained in popularity between the mid 1970s to the mid-1980s because of big spending on advertising and a shift away from other forms of tobacco, the report said, but that is changing, too.

"Snuff and chewing tobacco [illegible] down in the [illegible]

[illegible] have been placed on [illegible] and effective in late February [illegible] these totaling warning labels will appear on [illegible] less tobacco containers and in print advertising," the report said.

Specifically, it added, "The labels will warn consumers that the product may cause mouth cancer, gum disease and tooth loss, and that it contains nicotine and is addictive."

Verner N. Grise of the department's Economic Research Service said a USDA outlook briefing earlier this month that U.S. cigarette production may drop to about 650 billion "pieces" this year, a decline of 7 billion from 1986 and 78 billion below the 1981 production record.

Mr. Chairman and members of the committee: My name is Tom Easton, executive director for 35 years of the Montana Association of Tobacco and Candy Distributors.

This Montana association was organized in 1940. Its stated purpose is to advance relations and mutual understanding among manufacturers, wholesale and retail distributors, the consuming public, and government. Our objective is to improve economic conditions in these allied fields of endeavor. The membership is comprised of independent, family - owned small businesses, serving more than 1,000 retail stores, involving an estimated 30,000 men and women; owners and employees. I stress "small businesses"; some of them mom and pop stores. They do not include the large chain stores. They are independent of out of state or other manufacturers. A roster of our members and leaders is included with this testimony.*

One of our most important responsibilities is to evaluate proposed legislation and regulations to determine how they affect our members, the consumers and the economic health of our state government.

House Bill 676 has been carefully studied and our Montana association opposes it. We believe that no legislation merits adoptions unless it meets certain basic standards. As a minimum, proposed law should be necessary for the good of all the public and our government, must be appropriate in scope and practical in application. We believe HB676 fails to meet these standards. Therefore, we urge its rejection. HB676 proposes a radical legislative restriction of enjoyment of a wholly legal product—cigarettes. HB676 is a proposed solution for a problem that does not exist. HB676 if enacted would harm our state government and local and state government employees as a whole. For such a radical act would accelerate the downward spiral of revenue from a wholly legal product.

* Not attached to Secretary's copy

Modern technology in ventilation is in wide use. Such improvements are options for all other businesses serving the public. The important points are that the public and businesses continue to have the right and freedoms to exercise their options without government intrusion or dictation.

The costs to the private sector, and to government revenues, cannot be estimated if HB675 is adopted. However, the radical restrictions HB675 would require would have immediate and severe consequences to both the public and private business, as testified by others being heard.

HB675 assumes that employers and service businesses are not addressing the issue. The evidence indicates that employers and government are coping with whatever problems. Under current law, they have the authority to do so, and most need not be dictated to.

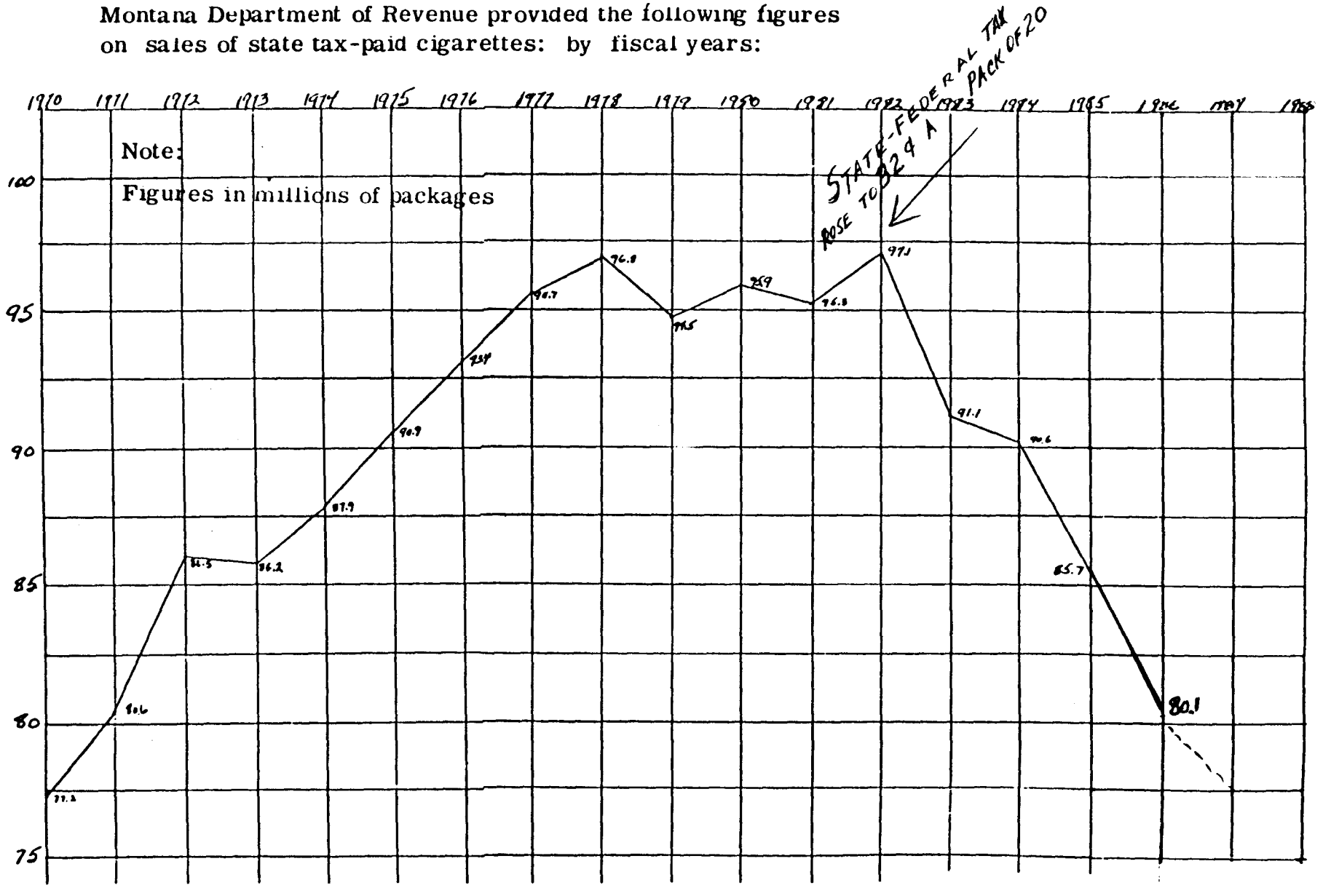
Is the bill practical? It does not take into account the vast differences of space among many different public places. The word "area" or "areas" appear in HB675 17 times. Yet no specific definition of an "area" is there. It leaves a health officer with being responsible to define an "area". It leaves a small diner or restaurant with no choice but to post signs telling smokers they are not welcome; no choice but to lose smokers' business.

HB675 is anti-business for all those whose livelihoods involve arranging gatherings -- conventions, educational seminars, mass food events of homogenous groups -- in a convention or meeting hall.

HB675 criminalizes smoking. $100 a day fining, continuing daily without limit, for non posting of signs, or $50 for lighting a cigarette in a nonsmoking area runs far ahead of inflation, since the current $25 fine was approved by the legislature.

"Signs" are important to HB675, but never defined specifically.

Montana Department of Revenue provided the following figures on sales of state tax-paid cigarettes: by fiscal years:



As a practical matter, where is the fiscal impact shown with HB675? How much would it cost the local health office or the state health department to carry out the enforcement which HB675 would require? Should there not be a fiscal note for HB 675?

Before any further law might be passed in this subject area — before any voting on HB675 — each committee member should ask this question and require answers:

HOW MANY PERSONS HAVE BEEN CHARGED WITH ANY VIOLATION UNDER THE CURRENT ACT, Section 50-40-102 through 50-40-201 ?

IF THE ANSWER IS:
"HARDLY ANY." (IF SO ANSWERED, DEMAND WHO, AND WHERE.)

IF THE ANSWER IS:
NOT ONE SMOKER. NOT ONE OWNER, MANAGER OR "PERSON IN CHARGE".
. . . . THEN ASK YOURSELF:
"WHY IS HB675 NEEDED?"
THE ANSWER IS:
HB 675 IS NOT NEEDED. THE PRESENT ACT IS WORKING.

Independent, Service . . .
Montana Wholesale Distributors of Tobacco products, candy, soft drinks, sundries

Warehouses	Personnisel
(Area Code 406)	O-owner P-principal EE-Executive OW-owner's wife PS-spouse EW-spouse
ANACONDA 59711	
Roach & Smith Distributors Inc.	Joe Markovich-0 (N. Keenan) 563-2835-home
403 Chestnut St.	Ruth Markovich-ow
	Dale Markovich-P (o?)
563-2041 - office	Maureen Markovich-ps
	Rich Todorovich (J Haffey
	Colleen Todorovich
BILLINGS 59103	
SERVICE CANDY Company	
P. O. Box 1794	Donald J. Bollinger-o
	Mary Ann Bollinger-o/ow (Jan-Mar)
252-2822 - office	1810 Avenida del Mundo
	607 EEncanto
	Coronado CA 92119
	Jack Bollinger-E
	Kay Bollinger-eo
	2038 St. Andrews Drive
	Billings MT 59101
	248-1491 - home
	Phil McBride--e
	Karen McBride - ew
	2501 Terry Ave.,
	Billings MT 59102
	William L. Warner-e
	Betty Warner - ew
	1043 Terry Ave.,
	Billings MT 59102
	252-5292 - home
BOZEMAN 59715	
Service Distributing Company	Steve Buckner - 0
P. O. Box 1887	412 E. Front st.)temporary address:
109 East Mendenhall street	Missoula MT 59802 Jan. -Mar)
1-800-221-0508	543 - 4755 - home
586 - 9183	Ellis Lewis (retiring June 15)--o
	Wanda Lewis -ow
	507 S. 11th Ave., Livingston MT 59047
B U T T E 59701	
Harkins Wholesale Inc.	William Harkins - o
445 Centennial Ave.	J. W. Harkins - o
	Jack Harkins - o
782 - 1268	809 West Silver Street
	Butte MT 59701
	723 - 3657 - home
GLENDIVE 59330	
Reynolds Wholesale Grocers	Kenneth B. McGovern - 0
109 S. Merrill Av. 365 - 2042	201 River Ave. 365 - 4349- home

GREAT FALLS 59403
Pennington's Inc.
P. O. Box 2546
911 River Drive
453 - 7628

C. L. Pennington - o
27 Prospect Drive
452 - 0427 - home

John Guza - e - Gen'l. Mgr.
141 Trailer Terrace
452 - 4258

Loy Ann Rembe - o
Karl Rembe - os

Susan Parker - o
Michael W. Parker - os

HAVRE 59501
Pennington's Inc. of Havre
P. O. Box 1720 X

265 - 5558

Lloyd J. Goulet - e

2135 1st Ave.
265 - 5117

HELENA 59624
Sheehan's of Helena Inc.
P. O. Box 1155
1324 Helena Ave.

442- 4333

Stan Feist - o
Dean Woodring - e
Reyna Woodring - ew
Blue Sky Heights - Box 42
Clancy MT 59634

933 - 5977

Stan Feist - o) See Sheehan-Majestic In
Tom Watson - o) Missoula

KALISPELL 59903
Glacier Wholesale Inc.
P. O. Box 5279
16 West Reserve Drive (59901)

752 - 4479

W. Allen Arlint - o
Betty Arlint - ow
555 Three Mile Drive
257 - 3397 - home

Bill A. Arlint - o
Linda Arlint - ow
50 Stonecrest Drive
752 - 6808

MILES CITY 59501
Gierke Distributing Co.
2 1 5 North 7th street

252 - 1563

George A. Gierke - o
Iola Gierke - ow
Yellowstone Valley - R. Rte.
232 - 1590 - home

Allen Gierke - o (use office address)
Tracey Gierke - ow
Robert (Bud) Gierke - o
Marge Gierke - ow
1502 Batchelor
232 - 0345 - home

MISSOULA 59807

Sheehan-Majestic Inc.
P. O. Box 7248
1301 S. 3rd West

543 - 5109

Stan Feist - o
Linda Feist - ow
543 - 4447

Thomas Watson - o
212 Crestline Drive
Missoula MT 59801
549 - 5934
Syndee Watson - ow

SHELBY 59474

Pennington's Inc.
P. O. Box 459
815 Oilfield Avenue

434 - 5141

Ben Ruff - e
Phyllis - eo
735 N. Marias Ave.
434 - 2756

Gary Ruff - e
Terri Ruff - eo

SIDNEY 59270

East-Mont Enterprises Inc.
P. O. Box 526
608 East Main street

482 - 2910

Alan Burgess - o
Rosemarie Burgess - ow

Miranda Burgess - o
1313 S. Central Avenue

482 - 2943

WOLF POINT 59201

Hi-Line Wholesale Co.
212 Benton Street

653 - 1313 - o

Tom B. Ault - o
Wanda Ault - ow
745 Knapp street
653 - 1008

Burl Ault - o (retired)
Eunice Ault - ow
123 East Johnson Street
653 - 2806

HELENA 59624

Montana Association of Tobacco and Candy Distributors Inc.

P. O. Box 1 2 3

442 - 1582

Thomas W. Maddox - executive director
Marilyn L. Maddox - secretary- eow
1777 LeGrande Cannon Blvd.,

442 - 1582

EXHIBIT ____
DATE 2-17-87
SB # 51

WITNESS STATEMENT

NAME Mary Mitchell BILL NO. SB 51

ADDRESS [illegible] Billings DATE 2/17/87

WHOM DO YOU REPRESENT? Montana Chapter of American Physical Therapy Assoc

SUPPORT ✓ OPPOSE ____ AMEND ____

PLEASE LEAVE PREPARED STATEMENT WITH SECRETARY.

Comments:

Please see copy of testimony distributed to committee members & secretary

CS-34

EXHIBIT [illegible]
DATE [illegible]
SB # 31

WITNESS STATEMENT

NAME [illegible] BILL NO. SB 31

ADDRESS [illegible] Bozeman DATE 2/17/87

WHOM DO YOU REPRESENT? Montana Chapter APTA

SUPPORT [illegible] OPPOSE _____ AMEND _____

PLEASE LEAVE PREPARED STATEMENT WITH SECRETARY.

Comments:

See prepared statement given to each committee member.

[illegible], PT

VISITORS' REGISTER

HUMAN SERVICES AND AGING COMMITTEE

BILL NO. SENATE BILL # 31 DATE February 17, 1987

SPONSOR SEN. JACOBSON

NAME (please print)	RESIDENCE	SUPPORT	OPPOSE
[illegible]	[illegible]	✓	
[illegible]	[illegible]	✓	
[illegible]	[illegible]	✓	
[illegible]	[illegible]	✓	
[illegible]	[illegible]	✓	
[illegible]	[illegible]	✓	
[illegible]	[illegible]	✓	
[illegible]	[illegible]	✓	
[illegible]	[illegible]	✓	
[illegible]	[illegible]	✓	
[illegible]	[illegible]	✓	
[illegible]	[illegible]	✓	
[illegible]	[illegible]	✓	
[illegible]	[illegible]	✓	
[illegible]	[illegible]	✓	
[illegible]	[illegible]	✓	
[illegible]	[illegible]	✓	
[illegible]	[illegible]		✓
[illegible]	[illegible]		

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

PLEASE LEAVE PREPARED STATEMENT WITH SECRETARY.

VISITORS' REGISTER

HUMAN SERVICES AND AGING COMMITTEE

BILL NO. SENATE BILL NO. 31 DATE FEBRUARY 17, 1987

SPONSOR SENATOR JACOBSON PAGE TWO

NAME (please print)	RESIDENCE	SUPPORT	OPPOSE

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

PLEASE LEAVE PREPARED STATEMENT WITH SECRETARY.

VISITORS' REGISTER

HUMAN SERVICES AND AGING COMMITTEE

BILL NO. HOUSE BILL NO. 752 DATE FEBRUARY 17, 1987

SPONSOR REP. WINSLOW

NAME (please print)	RESIDENCE	SUPPORT	OPPOSE

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

PLEASE LEAVE PREPARED STATEMENT WITH SECRETARY.

VISITORS' REGISTER

HUMAN SERVICES AND AGING COMMITTEE

BILL NO. HOUSE BILL NO. 749 DATE FEBRUARY 17, 1987

SPONSOR REP. SQUIRES

NAME (please print)	RESIDENCE	SUPPORT	OPPOSE
Bill LEARY	HELENA	✓	
ELSIE Lafferty	MSCA	✓	
ALICE CAMPBELL	MSCA	✓	
ROSE SKOOG	MT Health Care Assn	✓	
[illegible]	MSCA	✓	
[illegible]	[illegible]	✓	
[illegible]	[illegible]	✓	
[illegible]	[illegible]	✓	
[illegible]	[illegible]	✓	
[illegible]	[illegible]	✓	
[illegible]	[illegible]	✓	
[illegible]	[illegible]	✓	
Charlie Brick	Attorney Office	✓	
[illegible]	Helena		

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

PLEASE LEAVE PREPARED STATEMENT WITH SECRETARY.

VISITORS' REGISTER

HUMAN SERVICES AND AGING COMMITTEE

BILL NO. HOUSE BILL # 675 DATE February 17, 1987

SPONSOR REP. MILES

NAME (please print)	RESIDENCE	SUPPORT	OPPOSE
DEAN CENTER	[illegible]	✓	
[illegible]	Billings, MT		✓
[illegible]	[illegible]		✓
C.E.M. TURNER	[illegible]		✓
[illegible]	[illegible]		✓
[illegible]	Great Falls		✓
[illegible]	[illegible]	✓	
[illegible]	[illegible]	✓	
[illegible]	[illegible]	✓	
[illegible]	[illegible]	✓	
[illegible]	[illegible]	✓	
[illegible]	[illegible]	✓	
[illegible]	[illegible]	✓	
[illegible]	[illegible]	✓	
[illegible]	[illegible]	✓	
[illegible]	[illegible]	✓	
[illegible]	Helena	✓	
Tom Maddox	[illegible]		✓
DAVID [illegible]	[illegible]	✓	

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

PLEASE LEAVE PREPARED STATEMENT WITH SECRETARY.

VISITORS' REGISTER

HUMAN SERVICES AND AGING COMMITTEE

BILL NO. HOUSE BILL # 675 DATE February 17, 1987

SPONSOR REP. MILES

NAME (please print)	RESIDENCE	SUPPORT	OPPOSE
John Delano	Helena		

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

PLEASE LEAVE PREPARED STATEMENT WITH SECRETARY.