



Labored Breathing

Policies to Eliminate Environmental Tobacco Smoke Exposure in North Carolina

Adam O. Goldstein, MD, Sally Herndon Malek, MPH, Anne Y. Butzen

Tobacco use is the leading cause of preventable death in North Carolina. Each year it leads to over 13,000 deaths, and over \$400 million in health care costs.¹ Environmental tobacco smoke (ETS) exposure occurs when nonsmokers inhale tobacco smoke generated by others. ETS is a major health problem in the US and North Carolina. In this article we summarize scientific knowledge about ETS exposure, exposure levels in North Carolina, the attitudes of North Carolina citizens and policy-makers about ETS, current efforts to extend protection from ETS, barriers to protection, and suggested future directions for policy activity.

The Science of Environmental Tobacco Smoke

ETS is classified as a human lung carcinogen by the Environmental Protection Agency. It causes at least 3,000 cases of lung cancer among nonsmokers every year in the U.S.² Smoke from an idling cigarette contains nearly twice as much tar and nicotine, up to five times more carbon monoxide, and 50 times more ammonia than smoke that is directly inhaled.³

Among the toxic constituents of ETS are carbon monoxide (which leads to heart disease and fetal damage), nitrogen oxide (leading to nitrosamine formation and cancer), ammonia (a respiratory and eye irritant), methylisocyanate (a lung poison), hydrogen cyanide (the lethal gas used in execution chambers) and nicotine. ETS contains over 40 cancer-causing agents,³ including benzo [a] pyrene (a cause of lung cancer), nitrosamines (lung and respiratory tract cancer), aromatic amines (cancer of bladder and breast),

benzene (leukemia), formaldehyde (nasal cancer), and radioactive polonium-210.³

Scientific evidence about the health effects of ETS has been building for more than 30 years. In the 1970s, US government reports showed that “an atmosphere contaminated with tobacco smoke contributes to the discomfort of many individuals”; in 1986, the Surgeon General reported on the dangers of involuntary exposure to ETS and recommended strong action to limit exposure.⁴ In 1991, the National Institute of Occupational Safety and Health said that “employers should protect nonsmokers from ETS by isolating smokers” and reducing exposure to the lowest feasible concentration.⁵

The yearly number of ETS-related cardiovascular deaths exceeds the number of ETS-related lung cancer deaths by a factor of 10-20.³ There are 4,000 heart disease deaths and more than 400 lung cancer deaths annually among office workers exposed to ETS in the workplace.⁶ Exposure to ETS increases carotid atherosclerosis, even among healthy people, and “some adverse effects may be cumulative and irreversible.”⁷ The largest study followed 450,000 nonsmokers from 1982 to 1989. Those exposed to ETS had a 30% higher rate of death from heart disease than those not exposed.⁸ In a comprehensive 1999 review, the National Cancer Institute and the California Environmental Protection Agency concluded that ETS is causally related to many diseases, including cancer and heart disease.³ In total, ETS causes 65,000 deaths a year in the US and approximately 1,500 in North Carolina (Table 1).

Dr. Goldstein is an Assistant Professor and Anne Butzen is a Research Assistant in the Department of Family Medicine, UNC-Chapel Hill. Ms. Malek is Head of the Tobacco Prevention and Control Branch, NC Division of Public Health, Department of Health and Human Services. Address correspondence to Dr. Goldstein at UNC School of Medicine, CB# 7595, Chapel Hill 27599-7595. Phone: 919/966-4090; e-mail: aog@med.unc.edu.

Public Knowledge, Attitudes and Behaviors about ETS Exposure in North Carolina

Public surveys show that North Carolina citizens experience adverse health effects from ETS exposure, that they are aware of ETS-related health effects, and that they want more protection from it (Table 2).⁹⁻¹¹ Approximately 70% of North Carolinians know that breathing ETS is harmful and causes lung cancer.⁹ One out of three North Carolina adults reports that someone smokes tobacco in their home every month. Nearly 30% of working North Carolina adults do not have a smoke-free policy at their place of work.^{10,11} Two-thirds of North Carolina adults with asthma know that their asthma is worsened by secondhand smoke.⁹

A 1996 survey showed that 70% of North Carolinians who are exposed to ETS are exposed by their spouse or life partner.⁹ Twenty percent of newborn babies live in a home with a smoker.¹² A study of airports, shopping malls, roller rinks, and other indoor entertainment facilities revealed that well over 400,000 adults and 100,000 children are exposed to ETS every week in these common public facilities.¹¹ A recent study by the NC Division of Public Health found that nearly 33,000 children in North Carolina had experienced some degree of respiratory distress.¹² Sixty-five percent of asthmatics describe a worsening of symptoms after exposure to ETS in the workplace.⁹

Adults in North Carolina strongly support limiting public exposure to ETS (Table 2); 62%-75% of them prefer smoke-free restaurants, feel that businesses should do more to protect employees and customers from secondhand smoke, believe that smoking should not be allowed in some or all indoor work areas, and believe that government should regulate smoking in public places.⁹ Business owners and managers agree that ETS exposure is a public health problem, that it causes heart disease and lung cancer, and that their facilities should be smoke-free.¹¹

Policy Options to Reduce ETS Exposure

Several policies have been proposed to reduce ETS exposure, but some are not viable options. The tobacco industry touts the establishment of designated smoking areas, believing that it is possible to

Table 1. Diseases caused in the US by environmental tobacco smoke exposure³

<i>Diseases</i>	<i>No. of cases</i>
New asthma cases	26,000
Existing asthma exacerbations	1,000,000
Bronchitis/pneumonia	300,000
Hospitalizations in children	15,000
Lung cancer deaths	3,000 (81 in NC)
Heart disease deaths	62,000 (1674 in NC)

“accommodate” smokers and nonsmokers in public places.¹³ The problem is that smoking and non-smoking areas usually occupy the same room. ETS diffuses rapidly throughout the room, resulting in substantial exposure among nonsmokers. More than a quarter (26%) of North Carolinians report that their workplace smoking rules assign designated smoking areas inside their workplace.¹⁰ Because of air re-circulation through central ventilation systems, it is likely that most workers have high levels of ETS exposure at work (each smoker would need about one million square feet of building area to produce minimal safe ETS exposure levels).¹⁴

Another policy proposes separately ventilated areas in public places. When these designated smoking areas do not leak, they adequately protect nonsmokers, but there are two

Table 2. Knowledge, attitudes and behaviors of North Carolinians regarding ETS exposure¹¹

<i>Statements</i>	<i>Those agreeing</i>
<i>Knowledge</i>	
Secondhand smoke can cause lung cancer	70%
Secondhand smoke can cause earaches in young children	35%
Secondhand smoke can cause babies to be born prematurely	66%
<i>Attitudes</i>	
Support smoking restrictions at outdoor sporting events	58%
Support government regulation on smoking in public places	62%
Support restrictions on smoking in restaurants	95%
Feel there should be smoking restrictions in clubs and bars	76%
Feel there should be no smoking at all in schools	88%
Feel the most appropriate workplace policy is no smoking or limit it to outside	82%
Feel there should be smoking restrictions in bowling alleys	90%
<i>Behaviors</i>	
Workers report secondhand smoke-related discomfort (among those exposed)	43%
Prefer to eat in restaurants that are smoke-free	64%
Asthmatics report worsened symptoms around secondhand smoke	65%

concerns: designated smoking areas may actually increase the health risks of smoking; and the installation of separately ventilated smoking lounges is very costly.

Table 3. North Carolina Tobacco Prevention Control Branch ETS policy objectives 2001-2010²⁹

Objectives	Current	Goal for 2002	Goal for 2004	Goal for 2010
Percentage of schools that are completely smoke-free	11%	15%	30%	100%
Percentage of workers in public and private work sites covered by a formal policy prohibiting smoking entirely or limiting it to separately ventilated areas	61%	63%	81%	100%
Percentage of North Carolina citizens reporting completely smoke-free homes	53%	58%	63%	74%
Percentage of middle and high school students who live with someone who smokes	46%	42%	36%	24%

The healthiest and least costly policy option is to eliminate public smoking, and thus eliminate ETS exposure altogether. Workplace smoking bans effectively reduce nonsmokers' exposure to ETS. One study found a strong correlation between airborne nicotine concentrations and workplace smoking policies (median nicotine concentrations fell from 8.6 $\mu\text{g}/\text{m}^3$ in open offices that allowed smoking, to 1.3 $\mu\text{g}/\text{m}^3$ in those that restricted smoking, to 0.3 $\mu\text{g}/\text{m}^3$ in sites that banned smoking.¹⁵

Legislative Policy Options

North Carolina currently has no statewide laws protecting its citizens from ETS exposure. Instead, it has a law (GS 143-597: Smoking in Public Places) stating the legislative intent to "address the needs and concerns of both smokers and nonsmokers in public places by providing for designated smoking and nonsmoking areas."¹⁶ Yet the law does not require smoke-free areas in state government or private work sites, or in restaurants; it does allow libraries, museums, and health care instructional buildings to be "designated as nonsmoking." State controlled buildings, like auditoriums, may establish nonsmoking areas if at least 20% of the interior space (including 20% of lobbies) is designated for smoking unless it is "physically impracticable." And even when areas are designated as nonsmoking or smoking it is not required that existing ventilation systems be modified to reduce or eliminate ETS exposure. The law exempts schools, child care centers, public school buses, hospitals, nursing homes, health departments and nonprofit agencies whose primary purpose is to discourage tobacco use.

Unfortunately, North Carolina's law (GS 143-597) prohibits local governments from enacting any new public health ordinances for clean indoor air.¹⁶ State laws of this

kind are called *preemptive* because they restrict local counties from passing indoor air regulations that are stricter than the statewide clean indoor air law. North Carolina's preemptive legislation was introduced in April 1993 to protect the "rights" of smokers and supposedly to reduce confusion among North Carolinians who might be subjected to smoking regulations in one county and not in another.

When the NC General Assembly passed the law in July 1993, it gave local public health advocates three months in which to pass clean indoor air ordinances, after which all future ordinances were preempted. Public health advocates responded by getting city councils, county commissioners, and boards of health to pass 89 local smoking rules in North Carolina.¹⁷ Most of these regulations were passed by county boards of health, and exempt small restaurants and bars, for fear that prohibiting smoking would impose an unfair economic burden. The speed with which these new local ordinances were passed came at a price: there was little time for local coalitions to educate their communities about ETS as a health hazard and to build outspoken community support for the ordinances that were enacted.¹⁷

In November 1993, lawsuits contesting local smoking ordinances were filed against the Boards of Health in four counties. Buncombe County won its case at the local level; Guilford County, under threat of suit, withdrew its proposed rules; Wake County suspended enforcement of its rules under pressure from restaurants supported by the tobacco industry.¹⁸ The Halifax District Court, in a suit brought by cities and business in the county, ruled that the Halifax County Board of Health ordinance was illegal because it referred to economic impact.¹⁹ The court ruled that the Board of Health had the right to pass only health-related rules, and had erred by taking economic factors into consideration. Smoking regulations were thus made null and void. The ruling was not subsequently appealed, and so all similar

ordinances passed across the state are now in question.¹⁹ North Carolina citizens and public health advocates have few legislative policy options. Since GS 143-597 became fully in effect, no local communities in the state have enacted ETS legislation, and many local rules have been suspended.

Policy options do exist. As suggested by the University of North Carolina Institute of Government,¹⁹ advocates can bring forth local legislation within the limits of the preemptive law. Federal statutes preempt state law if the two conflict, and people disabled by smoking or secondhand smoke are guaranteed the right to a minimally healthy environment by the Eighth Amendment of the United States Constitution.

Another policy option is to use the complex language of the preemptive law to push for more appropriate standards. For instance, state buildings must set aside 20% of their interior space for smoking areas, unless such a rule is “physically impracticable.” Some managers of state controlled buildings have deemed the space too small or ventilation systems inadequate to protect the health of nonsmokers. They could then adopt 100% ETS-free policies.

Day care centers, schools, health care facilities, and persons with disabilities are all protected by Federal law. Schools (both school buildings and school grounds) can have 100% smoke-free policies that apply to students, faculty, and visitors on campus, and apply at all school-sponsored events.²⁰

The legislative policy option that offers the greatest public health gains is the most difficult to achieve: repealing North Carolina’s preemptive tobacco law (GS 143-597), or passing a truly protective state clean air measure. It is very difficult to overturn preemptive tobacco laws. Over the last decade, 16 states have passed tobacco industry-sponsored preemptive legislation, and none has successfully repealed the laws. Only Vermont and California have enacted comprehensive clean air legislation. Overturning preemption or passing true clean air legislation will be even more difficult in North Carolina, with its historically friendly relationship between the tobacco industry and the legislature.

Regulatory Policy Options

Some people affected by exposure to ETS have sought regulatory refuge under the Americans with Disabilities Act (ADA), which prohibits places of public accommodation from discriminating on the basis of disability.²¹ Public facilities—courthouses, jails, hospitals, parks, and other facilities owned and operated by State and local governments—

Table 4. North Carolina Tobacco Prevention Control Branch ETS Strategies 2001-2010

- ◆ Educate individuals and organizations on the need for smoke-free policies, the link between asthma and ETS, and smoking in homes
- ◆ Promote policies at schools and work sites to eliminate ETS exposure
- ◆ Meet with owners and managers of facilities that currently allow tobacco use
- ◆ Encourage customers and influential citizens to voice their desires about limiting ETS
- ◆ Conduct paid media campaigns about ETS exposure
- ◆ Promote and support businesses that are smoke-free
- ◆ Promote role models for ETS-free lifestyles
- ◆ Promote in-home inspections and quit-smoking services for families of asthmatics

cannot discriminate in their services because of race, color, religion, national origin or disability. Under the law, a disability is defined as physical or mental impairment that substantially limits one or more major life activities. People with chronic respiratory illnesses such as asthma have filed claims under the ADA, claiming successfully that breathing is one of life’s “major activities.”

One does not have to hire a lawyer and file a claim to use the ADA. Often it is only necessary to inform an employer about the ADA, whom it protects, the potential publicity generated by claims, and other peoples’ successful claims. For instance, the Piedmont Triad International Airport changed its policy on ETS in large part because of public pressure from local groups in Greensboro and SAVE (Survivors and Victims of Tobacco Empowerment Program). SAVE publicized the ineffective policy in place, demonstrated exposure of those with smoke-sensitive medical conditions, and generated substantial publicity. As a result, the Airport authority changed its ETS policy from a permissive one with pervasive exposure to a restrictive policy that confined smoking to separately ventilated, enclosed rooms.²²

Using the ADA to advance ETS policy change can take a long time and may require legal representation in order to expedite the process, but ultimately success is possible. In 1995, three asthmatic children and one adult with lupus brought a case against Burger King and McDonald’s claiming that the restaurant chains’ policy of allowing smoking in their facilities violated the ADA’s public accommodations provisions. A court ruled that a smoking ban in the restaurants “would fully accommodate the plaintiffs’ disabilities but impose little or no cost on defendants.”²³

Voluntary Policy Options

In addition to strengthening legal regulations, employees, students, consumers, citizens and public health advocates have worked for voluntary policies that prohibit smoking at work sites, recreational facilities, homes, and schools. The percentage of workplaces reported to be smoke-free has risen from 31% in 1993 to 61% in 1999, but North Carolina

workers still lag behind the national average of workplaces protected by a smoke-free environment (68.5% in 1999²⁴). Surveys of restaurants vary, but a recent poll showed that only 25% of restaurants in the state are completely smoke-free (North Carolina Department of Health and Human Services. Unpublished data, 1999). Even North Carolina's schools have seen a slow rise in school districts that have 100% smoke-free policies (from 6% to 11%).

The Future of ETS Policies in North Carolina

Over the last three years, new opportunities for implementing effective tobacco control policies and reducing ETS exposure have emerged in North Carolina. These include (1) revelations about biased research on ETS by the tobacco industry,²⁵ (2) heightened public awareness of adverse health effects of ETS exposure, (3) increased awareness of how the ADA provides opportunities to gain smoke-free accommodations for breathing-impaired people, (4) increased access to relevant survey data, and (5) increased collaboration among interested parties.

Several health care coalitions in North Carolina have set the reduction of ETS exposure as a policy objective. The North Carolina Tobacco Prevention and Control Branch has established long-term (by 2010), short-term (by 2004) and immediate (by 2002) plans and strategies for eliminating exposure to ETS (Tables 3, 4).

Asthma coalitions have surveyed middle school students about asthma and ETS. The NC Department of Public Health's "Start With Your Heart" campaign has canvassed restaurants, promoting "Heart Healthy" dining experiences, which include a smoke-free atmosphere. The Tobacco Prevention and Control Branch has published the comprehensive *Grassroots Guide to Tobacco-Free Schools in North Carolina*. The Branch is working with the University of North Carolina Department of Family Medicine on a comprehensive *ETS Policy Advocacy Tool Box*, and on statewide training of public health advocates about the science of ETS.

Other organizations are using the ADA as part of their overall policy strategy. Currently, SAVE is leading efforts to have Ericsson Stadium in Charlotte change its policy to protect patrons from pervasive ETS exposure at the stadium. SAVE is also working to see that North Carolina's legislative buildings are smoke-free. It is imperative that employees and visitors have a smoke-free legislative building, particularly the 65,000 children who visit the building each year. Those wanting to eliminate ETS exposure in the NC Legislature cite data from the Industrial Hygiene Indoor Air Quality Survey for the North Carolina Legislative Office Building. The survey concluded that "Smoking in the [legislative] building can only serve to degrade the air quality . . . [t]he only way to effectively control the smoke . . . would be to limit smoking to areas under a negative pressure relative to the rest

of the building exhausted directly to the out-of-doors." The report states that this problem will be solved by barring cigarette smoking entirely from the workplace.²⁶

Public health advocates agree that we need more private and public policies to protect the health of North Carolina's citizens. Overturning North Carolina's preemptive clean indoor air law would help; the key to this is increased public awareness of the health hazards of ETS exposure and public demands for protection.

Local coalitions continue to generate support for voluntary policy change, but there is still a great need for a statewide media campaign focusing on the risks of ETS. Survivors of tobacco related illnesses, affected family members, and smoke-sensitive children could effectively communicate the need for smoke-free air and form the core of such a media campaign. Ultimately, combined media and community level policy advocacy to eliminate ETS may optimally protect North Carolina's adults and children.

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Editor's note: Several weeks ago a school teacher sent us the following letter:

My fourth grade surveyed students in grades 3-5 with the question, “Do you live with a smoker?” Over half of the approximately 300 students answered yes. A review of attendance records showed that students who live with smokers miss 29% more school days than those who don't. That's about 2 extra days a year missed by children who breathe second-hand smoke! I suspect, also, that there are correlations with decreased test scores and learning disabilities.

My principal does not want this to go public because she is afraid of angry parent reactions. So I ask that you protect my anonymity. It seems to me, however, that if the word got out a lot of parents might start stepping outside to smoke and not smoke in the car when kids were with them. I'm stuck. What do you suggest?

We forwarded it to Dr. Goldstein, who replied:

As a teacher, you well know the adage, ‘Children bring to school what they learn from home.’ Thus, it is not surprising (although it is shocking) that tobacco use is not declining much among middle school students in North Carolina when so many parents still smoke. It is even worse to know that parents’ tobacco addictions adversely affect the health of many children. Absences from school occur from bronchitis, pneumonia, and asthma exacerbation among children exposed to their parents’ secondhand smoke. Your ‘suspicion’ about test scores may also be correct; research conducted at UNC shows secondhand smoke exposure affects cognitive development in children.

Perhaps the greatest irony and disappointment here is that your principal is afraid to go public because of potentially angry parents. The ones who should be angry here are not those who smoke but the great nonsmoking majority of parents and policy makers across the state. Their anger should be aimed at the fact that some parents make their children inhale a cancer-causing substance. Increasingly, courts are interpreting parents’ callous and continuous exposure of their children to secondhand smoke as a form of child abuse.

We clearly need to educate all parents about secondhand smoke and the need to eradicate exposure of their children, spouses, and friends. Children can be a vehicle for that education. I hope your students take multiple messages home to their parents, write letters to local newspapers, write the local Mayor and city council, and even contact the principal about their concerns. As a boy of 10, I got my mother to stop smoking 30 years ago. Perhaps 30 years from now, our students and children will not have to ask their parents to stop an addiction that ultimately kills as many as one out of two smokers and one out of 55 who are exposed to secondhand smoke.