The Scottish Parliament
Pàrlamaid na h-Alba

Official Report

HEALTH AND SPORT COMMITTEE

Tuesday 1 September 2015

Session 4

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HEALTH AND SPORT COMMITTEE
22nd Meeting 2015, Session 4

CONVENER

*Duncan McNeil (Greenock and Inverclyde) (Lab)

DEPUTY CONVENER

*Bob Doris (Glasgow) (SNP)

COMMITTEE MEMBERS

*Rhoda Grant (Highlands and Islands) (Lab)
*Colin Keir (Edinburgh Western) (SNP)
*Richard Lyle (Central Scotland) (SNP)
*Mike MacKenzie (Highlands and Islands) (SNP)
Nanette Milne (North East Scotland) (Con)
*Dennis Robertson (Aberdeenshire West) (SNP)
*Dr Richard Simpson (Mid Scotland and Fife) (Lab)

*attended

THE FOLLOWING ALSO PARTICIPATED:

Professor Linda Bauld (University of Stirling)
Simon Clark (Freedom Organisation for the Right to Enjoy Smoking Tobacco)
Sheila Duffy (ASH Scotland)
Andy Morrison (New Nicotine Alliance (UK))

CLERK TO THE COMMITTEE

Jane Williams

LOCATION

The James Clerk Maxwell Room (CR4)

Scottish Parliament

Health and Sport Committee

Tuesday 1 September 2015

[The Convener opened the meeting at 10:20]

Decision on Taking Business in Private

The Convener (Duncan McNeil): Good morning and welcome to the Health and Sport Committee's 22nd meeting in 2015. As I usually do at this point, I ask everyone in the room to switch off mobile phones, as they can often interfere with the sound system. I point out to those who have not previously attended a committee meeting that they will see officials and members using tablet devices instead of hard copies of the committee papers.

We have received apologies from Nanette Milne.

Agenda item 1 is a decision on whether to take consideration of a draft stage 1 report on the Carers (Scotland) Bill in private at item 7 in this meeting and at future meetings. The committee is also invited to agree to take consideration of a draft report on national health service boards budget scrutiny in private at future meetings. Does the committee agree to do that?

Members *indicated agreement.*

Health (Tobacco, Nicotine etc and Care) (Scotland) Bill: Witness Expenses

10:21

The Convener: Under item 2, members are invited to agree to delegate to me the onerous responsibility for arranging for the Scottish Parliamentary Corporate Body to pay, under rule 12.4.3 of standing orders, the expenses of witnesses who give evidence on the Health (Tobacco, Nicotine etc and Care) (Scotland) Bill. Does the committee agree to do that?

Members *indicated agreement.*

Health (Tobacco, Nicotine etc and Care) (Scotland) Bill: Stage 1

10:22

The Convener: Item 3 is our first evidence session on the Health (Tobacco, Nicotine etc and Care) (Scotland) Bill. I welcome to the committee Sheila Duffy, chief executive of ASH Scotland and chair of the Scottish coalition on tobacco—thank you for attending; Professor Linda Bauld, professor of health policy at the University of Stirling; Simon Clark, director of the Freedom Organisation for the Right to Enjoy Smoking Tobacco—FOREST; and Andy Morrison, trustee of the New Nicotine Alliance. Welcome to you all.

I have received no notification that any of you intends to make an opening presentation, so we will move straight to questions and take it from there. Richard Lyle will ask the first question.

Richard Lyle (Central Scotland) (SNP): A number of months ago, I convinced the committee to have a morning session on NVPs—nicotine vapour products. How do you feel about the suggestion that we should ensure that such products are not sold to children by putting an age limit on them? What is your opinion on advertising?

Professor Linda Bauld (University of Stirling): Thank you very much for the questions. There was almost universal acceptance in the responses to the consultation on the bill that we need an age restriction on nicotine-containing products, and there is a commitment to bring Scotland into line with the rest of the United Kingdom by introducing an age-of-sale limit of 18. There is no reason why a child who has never smoked and never used a nicotine product should start using nicotine, so even among members of the smoking and vaping community, there is strong support for an age-of-sale limit.

Your second question was about advertising, which is a more difficult issue. I have spent 17 years doing research on smoking cessation—helping people to stop smoking—and my view is that we still need some forms of e-cigarette advertising to encourage smokers to switch to less harmful products. The team that drafted the bill has tried to strike a balance by allowing point-of-sale marketing or advertising while restricting some of the channels that will not be covered by European legislation and which might appeal to children. We might have a longer discussion about that, but those are my starting thoughts on those two issues.

Andy Morrison (New Nicotine Alliance (UK)): I agree with what Linda Bauld said: we do not want under-18s to pick up these devices. However, we have several issues on advertising. We should not stifle advertising too much; we want responsible advertising to help in the fight against tobacco products. We want to give e-cigarettes the leading edge over tobacco products, so we would welcome responsible advertising being allowed.

The Convener: Would anyone else like to contribute?

Simon Clark (Freedom Organisation for the Right to Enjoy Smoking Tobacco): Like the other speakers, we would oppose excessive restrictions on advertising e-cigarettes. It makes sense to encourage people to switch from combustible cigarettes to electronic cigarettes, as long as they are not forced to do so. Therefore, it seems to be counterproductive if the regulations on advertising and marketing are too restrictive.

There should be a restriction on age of sale. There is an argument to be had over whether the age restriction should be 16 or 18. Until a few months ago, we were firmly of the opinion that it should be 18. As more evidence comes to the fore—Public Health England and the Royal Society for Public Health have said in recent weeks that e-cigarettes are potentially a lot less harmful than combustible cigarettes—it might be a courageous stance for the Scottish Government to take to create a clear marker between combustibles and electronic cigarettes and allow people to buy electronic cigarettes at 16.

Some children will always experiment and that is never going to be stopped. At the moment, a considerable number of children experiment with traditional cigarettes at the age of 16 or 17. Perhaps we should nudge them towards e-cigarettes. There is no evidence that e-cigarettes are a gateway to tobacco. We would not specifically support an age limit of 16, but it is worth having the discussion. If people are allowed to vote at 16, perhaps they are old enough to make their own decisions about nicotine at 16.

Sheila Duffy (ASH Scotland): We support an age restriction of 18 for consistency and because it is the internationally accepted age for protection. I have concerns about advertising. It is legitimate to want to make smokers aware of the products and the fact that tobacco is, on some estimates, 20 times more harmful. However, advertising could become a gateway for tobacco companies to reach young people, and we must watch that carefully, given their track record of exploiting advertising and marketing.

The Convener: There is the question whether the limit should be 16 or 18, and there is also the growing idea that harm reduction is better than smoking cigarettes. If it is good for someone at 19 to be able to access e-cigarettes as a means of

stopping smoking tobacco, why would it not be good for someone at 17?

Professor Bauld: A balance must be struck between supporting young people who are already using tobacco and not giving access to a nicotine-containing product to children who have never smoked. Whether the limit should be 16 or 18 is a tricky decision. The reason why Cancer Research UK—which I am primarily here on behalf of—supported an age of sale of 18 in our submission is, as Sheila Duffy said, for consistency with the rest of the UK and internationally. That is the age-of-sale limit that has commonly been adopted. However, the priority issue for the bill is not the 16 or 18 question; there are other much trickier issues in it.

The Convener: Does anyone else have a point on that issue? No.

Richard Lyle: I will move on to my other question, which I am sure that Mr Clark will want to respond to. My question is on the provisions on smoking in hospital grounds. At most hospitals, there are people standing outside having a cigarette. At Wishaw general hospital near me, under the regulations that the Government wants to introduce, people would have to go outside the hospital to smoke, which would mean about a quarter-of-a-mile walk—I have never measured it—to the hospital's outer periphery.

I abhor people standing outside the hospital entrance to smoke. A number of years ago, we legislated to prevent smoking in public places, so people do not smoke inside buildings, but they can do so outside.

I know that this is in your submission, Mr Clark, but would you suggest that, while you agree that smoking directly outside the building is wrong, there should be some form of shelter 100 to 200 yards away where people could go to smoke? I believe that 20 per cent of the population still smoke, and going to a hospital can be quite traumatic. Someone might have gone in to see a relation who has severe health problems that are not related to smoking, and they might come out and want to have a cigarette. Would you suggest that a shelter or something should be set up somewhere in the hospital grounds but outwith the hospital entrance?

10:30

Simon Clark: Thank you for raising that issue, which we feel strongly about. As you said, going to hospital as a patient or a visitor can be a stressful experience. It is also quite stressful for many members of staff. To ban smoking on all hospital grounds is totally inhumane and vindictive. It is petty—far pettier than banning smoking in pubs, because at least there people can still go outside. We are still firmly against the current comprehensive smoking ban, but to extend it to entire hospital sites is absolutely outrageous.

I accept that, when people go to hospital, it is not nice to see people standing and smoking around the entrance. That is not particularly nice for people who are walking past them, although that is often exaggerated. However, we have to look at the matter from a patient's point of view. I am thinking not just of patients who are in for one or two days but those who might be in hospital for eight or nine weeks. That might, for example, include an elderly person who is in for a hip replacement. They might be in hospital for eight or nine weeks and have very limited mobility. They will be told that they cannot go outside to smoke anywhere on the hospital grounds.

For a lot of patients in hospital, having the odd cigarette provides a comfort factor; they look forward to it. To deny them the right to have a cigarette anywhere in the hospital grounds is totally and utterly wrong.

The ban will be quite expensive to enforce. We have read newspaper reports in recent months in Scotland that a lot of people are ignoring smoking bans on hospital grounds. That is fine for people who are mobile and can go outside. What about people who are immobile? I had a call recently from the daughter of a woman who is aged 67, suffering from dementia and at a psychiatric hospital in Edinburgh. Lots of other patients can go outside, but because this woman is suffering from dementia, she cannot go outside on her own—it is unsafe. The staff were being threatened with disciplinary action if they took pity on her and took her outside.

There is a long history of staff taking people outside so that they can have a smoke if that is what they want to do, but now those same staff are being threatened with disciplinary action. Somebody who has a fantastic record of 20 or 30 years working for the NHS could find themselves penalised in some way—they could even lose their job—because they have taken pity on a patient and taken them outside for a smoke. That has to be wrong.

To go back to Richard Lyle's specific point, I do not see why hospitals cannot have smoking shelters. If they say that they cannot afford shelters, I would ask what is wrong with smoking 100 yards away from the building. I would not put a particular limit on that—people have to show a bit of common sense. Let us not have people smoking around the entrance, but anywhere else on hospital grounds should be allowed. People are not putting anybody else's health at risk by lighting a cigarette in the open air. Why should they be forced off hospital grounds and have to walk perhaps a quarter of a mile to a busy main road?

We put in our submission a case from about eight years ago, which I accept was an isolated one, when a nurse—I believe that she was at a hospital in Essex—was forced off hospital grounds to have a smoke and was murdered. I am not saying that that will be a regular occurrence, but we have to bear it in mind. People could be put at risk if they are forced further and further away from hospital grounds just to light a cigarette in the open air. That is totally wrong and utterly inhumane, and it goes against the so-called caring NHS.

The Convener: We need to be aware that we have limited time, and we need to be concise in our questions and responses, please. Does anyone else want to respond on the smoking perimeter?

Sheila Duffy: I am sorry; I should have made a SCOT 2015 declaration for the record that I and my organisation have no formal or informal financial or in-kind links to tobacco companies, their representatives or vested interests. I apologise for not making that declaration first.

I note that tobacco use and smoking are a very high risk factor for all forms of dementia. The aim in Scotland is to put tobacco out of sight, out of mind and out of fashion. As part of that, we have to be compassionate with people who are used to smoking and might have a physical addiction. The NHS is very good at offering all forms of support to people to manage that, which is important as part of any proposed restrictions.

Andy Morrison: The New Nicotine Alliance is delighted that e-cigarettes are not covered by these provisions. In other words, the law for them will not be the same as that for cigarettes. However, we are a bit disappointed that the majority of NHS buildings have decided to ban e-cigarettes on their grounds along with tobacco.

The Convener: We have received evidence about that. I think that there is a consensus that people are better to have an e-cigarette than a cigarette. Do you feel that banning e-cigarettes alongside tobacco would be a bit contradictory? Would that send the wrong message? We heard in evidence in the past that, if we treat people who use e-cigarettes the same as people who smoke, we will send the wrong message. Does that harm our actions in trying to get people to reduce their smoking?

Professor Bauld: As the bill is drafted in relation to hospital grounds, it is clear that e-cigarettes are not included in the enforcement and penalties that will follow. That is absolutely right. I am clear that we should not have banned e-cigarette use in NHS grounds in Scotland. The health boards' decision on that was wrong because, as the convener said, that sends the message that smoking e-cigarettes is like smoking and that they are potentially as harmful as smoking. Fortunately, the bill does not include e-cigarettes in the grounds provisions. That is key.

It is encouraging that the bill does not include any suggestion of uniformly banning e-cigarette use indoors in Scotland. In other words, it does not propose extending smoke-free legislation indoors to cover e-cigarettes. In contrast to Wales, that is the right decision, because we do not have the evidence of health harm from second-hand vapour in the way that we did for second-hand smoke.

The Convener: Does everyone support that view? Are there variations in that view among the witnesses?

Sheila Duffy: This is not a disagreement, but we would like the Scottish Government to work with partners to issue guidance as appropriate on policies for the indoor use of NVPs.

Simon Clark: It would be ludicrous to ban the use of e-cigarettes in hospital grounds. The only way in which we differ is that I am also against a ban on the use of cigarettes in hospital grounds.

Colin Keir (Edinburgh Western) (SNP): I would like clarification of something that Mr Morrison said in response to the opening question, on responsible advertising. Maybe it is just me, but how do we get a definition of responsible advertising? What is that? How do we define it?

Andy Morrison: I am talking about not targeting children and not glamorising the e-cigarette and about ensuring that advertising is aimed at current smokers and that it is all to get them off cigarettes or to give them an opportunity to get off cigarettes. We do not want to encourage any non-smokers, whether they be children or adults.

Colin Keir: How would you go about that? That is the thing. It is all very well talking about responsible advertising, but it is the definition that we are trying to get to. Not everybody will necessarily agree on that. The one thing that has always got me is how we ensure that people understand what responsible advertising is.

Andy Morrison: I cannot answer that question, other than to say that—

Colin Keir: In which case, how could we accept that there is—

The Convener: I am starting to enjoy this conversation, Colin, but it is a conversation. You need to allow some of the other witnesses to respond to your initial question about the importance in the bill of the role of advertising and what its target is.

Colin Keir: Apologies.

Professor Bauld: The Advertising Standards Authority has already put restrictions in place on e-cigarette advertising and it adjudicates on complaints that people make. It will consider the advertising and decide whether it is irresponsible.

I take the point that it is quite difficult to decide whether marketing reaches a child or, because it is a responsible advert, appeals only to an adult. That is why the bill team has been careful to ensure that the bill enables point-of-sale advertising to continue.

It could be argued that giving people information about the products at the point of sale and ensuring that effort is made to continue the appeal of those products to current smokers is necessary. It is important that we remove the forms of advertising that might glamorise products, such as giant billboards, but it is also important that some sort of advertising provides the information. The bill tries to strike the right balance on this tricky issue.

Simon Clark: On marketing and promotion, we have to be careful that we do not allow e-cigarettes to be promoted purely as a medicinal product. E-cigarettes have been popular with a lot of smokers because they see them as a recreational product, not a medicinal product. It is true that a lot of users are using them to cut down on or quit smoking, but there is also a pleasure aspect to vaping. If all e-cigarette advertising is turned into pharmaceutical advertising, the danger is that a lot of consumers will be driven away and smokers will not be attracted, because they will see the e-cigarette as a medicinal product, which is, frankly, less attractive than a recreational product.

Mike MacKenzie (Highlands and Islands) (SNP): My question is specifically for Professor Bauld. Do we have evidence to suggest that the cold-turkey method of smoking cessation is efficacious? Does it work?

Professor Bauld: The global evidence suggests that the vast majority of smokers who stop smoking do it in precisely that way: they do it unaided, using willpower alone. That might be because that is how they decide to do it, because they are not informed about the alternatives, or because the alternatives are not available in their country. However, we know that that is probably the worst way to stop, in terms of the chances of success. The global evidence suggests that the best way for a person to stop smoking involves a combination of two things: the use of a stop-smoking aid, such as nicotine replacement therapy, Champix or e-cigarettes, and support from a trained person—a nurse, a doctor, or even a helpline. Our studies have shown that that approach is about four times more successful than using willpower alone.

It is important to give people choice, however. If a person decides that they are going to throw away their pack of cigarettes tomorrow and not touch them again, and that works for them, that is great. We have to have lots of routes in.

Mike MacKenzie: Can I take it, then, that you are not in favour of an imposed cold-turkey solution?

Professor Bauld: I am not. Again, in the years that I have spent in this field, working with various groups—pregnant women, people with mental health problems and so on—I have seen that different things work for different individuals. We need to ensure that there are as many routes as possible out of using tobacco.

Mike MacKenzie: Are you concerned that there are aspects—

The Convener: The other witnesses are not here simply to witness our proceedings; they have to be given an opportunity to say something, if they want to.

Mike MacKenzie: I apologise, convener. I understood that Professor Bauld is the authority on this aspect.

The Convener: We have a panel of witnesses, Mike. It looks to me as if some of them want to come in, and we have to give them time to do so.

Mike MacKenzie: I apologise.

The Convener: Does Sheila Duffy want to respond?

Sheila Duffy: I agree with what Professor Bauld has said.

Andy Morrison: I agree as well, but I would say that the great thing about e-cigarettes is the diversity of the product. It is not a one-size-fits-all product, like a nicotine patch. You just slap a nicotine patch on and, if it works, it works and if it does not work, it does not work. Nicotine gum is the same—it works or it does not. There is a vast range of electronic cigarette devices out there, so people can mix and match. Everyone will find a solution. Not one person has come to me and said, “I don’t like these,” whose device I have not been able to change in some way, shape or form so that, within a week or so, they have stopped smoking. Electronic cigarettes are the way to go.

10:45

The Convener: Is there wider evidence on the use of the various devices?

Professor Bauld: It is a new area, and new studies are being published all the time. We have two randomised control trials that show that—using very old devices—e-cigarettes are as effective as nicotine patches in stopping smoking.

A recent study shows that people in the UK who stop smoking using electronic cigarettes are 60 per cent more likely to be successful at stopping smoking than those who use willpower alone or who buy nicotine replacement therapy over the counter.

Finally, an interesting new study differentiates between—as Andy Morrison mentioned—the basic cigalikes, which are the ones that look like cigarettes, and what we call tank devices, which are later-generation devices. That research shows that tank devices are more effective at helping people to stop, because they allow people to vary the amount of nicotine in them and are more effective at delivering nicotine. I agree with Andy that the effectiveness of devices varies. We need to study that in the longer term to see what works best for folk.

Mike MacKenzie: I want to bring the discussion back to the bill. Is the panel concerned about the provision that will prohibit smoking on hospital grounds? That could be seen as an imposed cold-turkey solution, and may engender a very negative response in taking forward the agenda of encouraging people to stop through more efficacious methods. Is the bill at risk of running contrary to the purpose that Sheila Duffy wants, which is a smoke-free Scotland by 2034 or whatever date?

Sheila Duffy: That will depend very much on how it is done. You have to communicate with people, offer them support and take them with you. That was the success of Scotland's legislation on smoking in indoor public places.

Mike MacKenzie: Forgive me, but I have heard that answer before and I have read it in the written evidence. I do not quite see how that gels with the descriptions that we have heard of smokers who are traumatised by visiting a sick relative or who have just had very bad news from their consultant, for example. A smoker's instinct is to light a cigarette to cope with whatever the situation is. You are saying to them, "We're offering you a long-term cessation treatment, but you're banned from smoking within a half-mile area." In-patients are also banned from smoking—they are absolutely prohibited from doing so—so there is a practical problem of their not being able to smoke, but you are saying that you want to offer long-term cessation.

Sheila Duffy: No. I am talking about the short-term management of the habit if there is a physical addiction. We need to offer people such support.

It is a myth that the tobacco companies perpetuate that smoking relieves stress. If you look at the research, you will see that there is an inverse relation. Former smokers and people who have never smoked report better wellbeing and less stress than smokers.

Mike MacKenzie: Let us leave that argument aside. What I am really—

The Convener: Mike—witnesses want to answer your question. There is a range of people with a range of views who all want to participate.

Mike MacKenzie: I am sorry, convener. I was just being mindful that you have told us throughout the meeting that we are short of time.

The Convener: You have had more than your fair share, Mr MacKenzie. There are panellists who want to respond to your question.

Professor Bauld: The hospital-grounds element of the bill is complex. Those of us who work in this field would agree that allowing smoking—even slightly away from the building—in the very place where people go to get well is not compatible with our spending millions of pounds in the NHS on treating smoking-related disease. That is the first principle.

The second principle you will see, when you look at what we know internationally about how to make new smoke-free policies work, even when they include hospital grounds, is that three things are needed: good policy, good enforcement and good communication with the public about what the policy is for and why it is happening. Those may be issues for regulations rather than for primary legislation, but it is important to keep them in mind. If we are to go down this route—I slightly disagree with Sheila Duffy in this regard—then we are not doing enough in the NHS to offer people alternatives that will help them to deal with their nicotine withdrawal when they are forced not to smoke, including in hospital grounds. We could do a lot more on that.

Simon Clark: I will repeat what I said earlier: it is totally wrong to ban smoking in all hospital grounds, and it is inhumane. I understand why hospitals do not want to appear to encourage people to smoke, but we have to be pragmatic and to live in the real world—not in some utopian smoke-free world where nobody gets comfort from lighting up. Whatever Sheila Duffy says, the reality is that a great many people enjoy and get comfort from smoking—especially in stressful situations, such as hospitals.

The Convener: Professor Bauld, will you take us to the next stage? Do you believe that the expected implementation of the bill will confirm the three key elements that you mentioned?

Professor Bauld: The way that the bill is drafted tries to strike the right balance, but we have learnt from smoke-free-areas legislation that specifying perimeters around buildings, how they will be enforced and all such aspects are very

important. My understanding is that such specificity will be for regulations rather than for the bill, but it is going to be challenging.

The Convener: Enforcement will be challenging, too.

Professor Bauld: From my reading of the bill—which I welcome, in principle—it is not clear who will enforce the extension of smoke-free areas.

Simon Clark: There should not just be a one-size-fits-all regulation for smoking outside. NHS hospital grounds vary enormously in size, so it should be left to the chief executive or the people who administer a particular hospital to make their own decisions. They should not have those decisions imposed on them by the central Government.

Rhoda Grant (Highlands and Islands) (Lab): I will go back to e-cigarettes and how they compare with ordinary cigarettes. Everyone is clear that e-cigarettes are more healthy. I cannot remember who provided it, but evidence that the committee has received says that only one brand of e-cigarette has been approved for nicotine replacement therapy but it is not available. Is that the case?

Professor Bauld: It is not actually an e-cigarette—it is a device called Voke, which is more like an asthma inhaler. It is made by Nicoventures, which is a branch of British American Tobacco that has been granted a medicines licence in the United Kingdom. The product has not yet come to market. It is not really an e-cigarette and it is the only such thing that we have. No electronic cigarettes are available as medicines anywhere in the world.

Rhoda Grant: If such a product is so successful in dealing with nicotine addiction, surely one way around this would be to have it registered as a medical device. I have always been a little concerned about the reluctance of those who make e-cigarettes to have them registered. Of course they will sell better if they are marketed as recreational devices, but that means that they also appeal to non-smokers. Surely, if we are talking about smoking cessation and addiction to nicotine, it would be better if such products were treated differently and not sold as recreational products.

Professor Bauld: Shall I start?

The Convener: We will put Andy Morrison on the spot.

Andy Morrison: Apart from the cost of making the companies jump through all the hoops at all the various stages that they would have to go through, the main problem with medicine regulation is that the devices are not one-size-fits-all. We could have a medical device but it would be only as effective as any other form of NRT—for example, some people get on okay with patches but some do not. It is not good enough to have only one type of device.

Electronic cigarettes work because of their diversity; we need to keep that diversity and keep developing the product. We started up with cigalikes just a couple of years ago—they are the little ones that look just like cigarettes—and I showed the committee a few seconds ago what we are on to now. We have moved on to really powerful and effective devices, and that move has been consumer driven. Putting a device through a medicine regulation process will mean that the end product will just not cut it. It will do for some people, but if we are going to have a consumer product it will work an awful lot better to let consumers drive innovation.

Professor Bauld: The issue is slightly outwith the bill. The European tobacco products directive, which is intended to come in next spring, will introduce a two-tier system in which devices that contain more than 20mg/ml of nicotine will have to go down the medicine licensing route and the other products will be allowed to remain as consumer products. That directive already exists.

It has been a difficult journey in the UK. The committee that I chaired at the National Institute for Health and Care Excellence—almost three years ago, now—recommended that there be medicinal e-cigarettes, but the Medicines and Healthcare Products Regulatory Agency process is so cumbersome and complex that few companies have been willing to put forward devices for medicines regulation. That includes companies in the pharmaceutical industry, which have not been interested. The only one that has come through is that single tobacco-industry-funded device.

We have a complex system that disincentivises such development, but we also have European legislation that will create a requirement, so the situation is going to change. I guess that the bill, which focuses on the wider issues around e-cigarettes, will just have to take into account that change in context.

Simon Clark: Linda Bauld knows a lot more about it than I do, but we have to make the leap away from seeing nicotine, in itself, as harmful. Only in the past couple of weeks, Public Health England declared quite authoritatively that nicotine is no more harmful than caffeine. Nicotine is closely associated with tobacco, so people leap to the conclusion that nicotine is harmful. We have to get away from that and see that nicotine is not a bad thing. Perhaps Linda Bauld could add to that.

Professor Bauld: A survey that the Royal Society for Public Health did earlier this month showed that, in the UK, about 90 per cent of non-

smokers and 75 per cent of smokers believe that nicotine is harmful, but we provide nicotine replacement therapy to pregnant women. The reason why we have allowed that since 2005 is, as Simon Clark said, that nicotine when it is delivered in a cleaner form is not a harmful drug. The harm that is caused is due to the 4,000 other chemicals in combustible tobacco, not the nicotine.

It is a tricky issue, and it probably contributes to some of the public misunderstanding about the relative risks of e-cigarettes versus tobacco cigarettes. As soon as people hear the word "nicotine", they think that e-cigarettes are potentially damaging. They are not risk free, but as an alternative to tobacco, they are certainly far safer.

Rhoda Grant: I think that it is widely understood that that is the case, but nicotine is highly addictive. Surely it is not a good thing to be addicted to something.

Andy Morrison: I am not so sure that nicotine is as addictive as people make out. It is certainly addictive within cigarette smoke, but we are beginning to find out that, on its own, it is not that addictive. It is about as addictive as caffeine. I have noticed that when I have gone through the process of switching from tobacco to vaping. I have just come off a four-and-a-half hour flight from Madeira, and not once did I have the feeling that I wanted to tear my hair out because I could not have a cigarette. I had my vaping gear on me, but it never bothered me in the slightest that I could not vape on the plane.

Professor Bauld: That is interesting. Nicotine in nicotine replacement therapy is not dependence forming; people do not generally get hooked on NRT and we do not see people continuing to buy it or use it. About 0.5 per cent of the population in the UK who were never smokers say that they use nicotine replacement therapy. If it was attractive, more people would use it.

We are also seeing that with e-cigarettes. Nicotine is dependence forming, but primarily in tobacco. We think that some of the other constituents in tobacco work with the nicotine to really hook people. The evidence that we are seeing is that people are not as reliant on the nicotine in e-cigarettes as they are on the nicotine when they are smoking. Again, however, we need longer-term studies to really understand the relationship in e-cigarettes.

Sheila Duffy: I welcome Andy Morrison's experience and I think that it is the experience of many people who use NVPs, but we also have to recognise that cigarettes are so addictive because they have been consciously engineered by tobacco companies over a number of years and with a lot of investment. We also have to recognise the strong footprint that tobacco companies have in the NVP market, which is likely to become stronger after the tobacco products directive takes effect.

The Convener: I suppose that that takes us to another aspect, which is the register of those who sell e-cigarettes. People would need to register in the same way as those who sell tobacco, and the consequences of selling to under-18s would be similar—the bill suggests that we should impose the same sort of restrictions on, and apply the same penalties for, selling e-cigarettes to under-18s. Would not that be disproportionate, given that we are talking about a less addictive product?

11:00

Andy Morrison: We would like a totally separate register for those who sell e-cigarettes, but I understand that that might be a costly process. I have been notified by the Scottish Government that the outward-facing part of the register will try to distinguish between NVPs and tobacco.

The Convener: Are there any other views on that?

Professor Bauld: I agree with that—I have made it very clear that I do not think that the same register should be used for both. I can see that the idea of a register is useful in giving trading standards officers a tool to enforce prevention of under-age sales, which we all agree is important, but I do not think that the same register should be used for sellers of NVPs and sellers of tobacco. It should certainly not be presented as the same register, because they are not the same products. We need to do much more to get rid of tobacco from Scottish society; we should definitely not focus on trying to get rid of e-cigarettes, because they might save some people's lives.

Sheila Duffy: There have been two advantages to having a register of those who retail tobacco. The first is that enforcement officers know who is selling it and where, and they can engage with and educate them. The other is that it allows academics to see how things change. We are talking about an emerging market that is very fluid, so such data would be very helpful. However, I agree with Linda Bauld and Andy Morrison that the register should look different for retailers who register to sell NVPs, because that might help to distinguish the products.

Dr Richard Simpson (Mid Scotland and Fife) (Lab): Rule 8 in the statement on the marketing of e-cigarettes that the Advertising Standards Authority will enforce is that

"Marketing communications ... must not encourage non-smokers or non-nicotine-users to use e-cigarettes."

If e-cigarettes are as safe as has been suggested—if they are completely harmless—why are we putting any restrictions on their sale? It seems to me that we need to recognise the cultural history of cigarettes. Smoking them was promoted—except by King James—as something that was very reasonable and which improved health. As a general practitioner, my father smoked and said that it was good for the lungs and encouraged them to exercise.

We have been through this process before. We are dealing with a very new area. I understand that there are some studies in the States that already suggest that the consumption of nicotine through NVPs—not through patches or other methods—is not entirely harmless. Perhaps Linda Bauld could tell us whether any research has been done on that. I also invite the witnesses to comment on whether the proposed restriction is reasonable. My final question on the issue of restrictions is whether advertising of e-cigarettes within a certain distance of schools should be banned, in order to not encourage youngsters to take them up.

Professor Bauld: I welcome some restrictions on advertising for precisely that reason. There are no good reasons why a child who has never smoked should start using such products; we all agree on that point. Nicotine is still dependence forming—it certainly is in cigarettes.

The other issue is that of inequalities. Why should kids spend their money on such devices when they do not need them? We must protect children from uptake, which is why the idea of restricting advertising is important.

As Sheila Duffy has highlighted, a range of questions exist about what will happen in the future and how such products will evolve. I agree. In the bill, an attempt is being made to balance risk and benefit. People who smoke at the moment will not be prohibited from accessing such products—in fact, they might be encouraged to access them—but an effort is also being made to keep an eye on the responsibility that we have in relation to protection.

Andy Morrison: That says it all. It is a case of having an approach that is proportionate to the risk.

Dr Simpson: The question is what the risk is. We just do not know what it is, do we? E-cigarettes are very new. Have any studies been done on harm?

Professor Bauld: You will know about the types of research that we have. Lab-based studies have been carried out that have tried to look at the constituents of e-cigarettes. They do not contain the tobacco-specific nitrosamines that you know are carcinogenic, but they contain very low levels of some of the harmful toxins that are present in tobacco, such as lead, cadmium and acetaldehyde. Therefore, I am not saying that e-cigarettes are risk free, but they are certainly far less harmful than tobacco. We can be relatively confident about that.

Without going into detail, I think that there are questions about long-term use, inhalation into the lungs and long-term exposure. We know about propylene glycol but perhaps not about some of the other constituents. Those are more research questions. If we are too restrictive, we could miss the public health prize of people switching. I agree, however, that the issue is not straightforward.

Dr Simpson: So we need good research.

The last bit of my question—

The Convener: Could we explore that point a little? Linda Bauld has mentioned nicotine replacement therapy for pregnant women. Could you explain to me, as a layman, the difference between a pregnant woman using a nicotine patch and a pregnant woman using an e-cigarette?

Dr Simpson: Patches do not have additives—but I am not supposed to give answers.

Professor Bauld: Richard Simpson, as one of the clinicians in the room, will correct me if I am wrong. The nicotine patch contains pharmaceutical-grade nicotine. The method of delivery has been rigorously tested in terms of safety and efficacy. If we leave aside the nicotine in e-cigarettes, which we do not have to worry about, the difference relates to the other constituents of e-cigarettes and the way in which the device delivers nicotine to the body. There may be some risks, although we are not seeing any evidence of that at the moment. E-cigarettes contain propylene glycol and flavourings, which have a number of constituents, so I think that Richard is right that there are longer-term questions about the potential impact of their use. When the comparison is with smoking, however, in relation to which we know so clearly what the harm is, I believe that we can be confident about the risk being far lower.

Sheila Duffy: Richard Simpson is right. We do not have good long-term knowledge yet about the effects of NVPs. There are some concerns about substances being taken in through the lungs as opposed to through the skin or the stomach—it is a slightly different agency.

NVPs are fairly obviously not as dangerous as tobacco, but, as we have said, that does not make them completely safe. There have been one or two flavourings that have had immediate risks attached, such as butterscotch, with diacetyl, and cinnamon, particularly when they are heated at high temperature, which is another factor. This is probably one to watch very carefully. I agree with

Linda Bauld that tobacco is undoubtedly and incredibly dangerous. Throughout this, we will have to keep our eye on the impact on tobacco use.

Dr Simpson: Convener, may I just—

The Convener: Andy Morrison is going to respond to that point. I will come back to you, Richard.

Andy Morrison: The flavouring problems are dealt with as they happen. As soon as a problem is identified, the product is taken off the market straight away and is replaced with something that is a lot more acceptable. The risk from e-cigarettes is probably 95 per cent less than that from tobacco, but there is room for improvement. The devices are improving as we go along. They now have heat protection, in that they cannot be heated to a temperature that will start producing formaldehydes. Because it is still a consumer-driven product, we are addressing the problems as we go along. I dare say that other problems will come up, no doubt, but they will not be anywhere near the scale of the problems caused by smoking combustible tobacco.

Dr Simpson: One of the things that concern me is that the tobacco industry is buying up NVPs. Those companies are doing it not for the good of our souls but for profit, and good luck to them in that—that is their job. However, what is to prevent them from putting back in the additives that strongly addicted people previously? We are saying that nicotine that is consumed through NVPs or through other methods may be less addictive than smoking tobacco, but what is to prevent the industry from creating and strengthening the market by adding in some of the additives that it has added in before, which are so damaging?

Professor Bauld: I agree that the industry is very effective at getting round whatever restrictions are put in its way and it has huge resources behind it. The European tobacco products directive requires—primarily for the consumer product rather than the medicinal product, which would have to go down the licensing route—contents to be clearly described and the development of the devices and their constituents to be more clearly labelled. What the industry has to declare will be a very complex document. I do not know whether that will deal adequately with the issue that Richard Simpson raises. It is however part of the European TPD.

Andy Morrison: The tobacco industry's products are useless—they are absolutely hopeless. No seasoned vaper would bother with the products that the tobacco companies are putting on the market at the moment. The products just do not cut the ice, so to speak; they are useless. Maybe that is deliberate; I do not know—it could well be. The tobacco companies do not want the products to work. Generally speaking, anyone who knows enough about vaping will not buy one of those products—they are few and far between, to tell you the truth.

Dr Simpson: Well, I—

The Convener: Sheila Duffy wants to respond as well. There you go—if you give the witnesses a chance, they will respond.

Sheila Duffy: I share Andy Morrison's concern that tobacco companies may consciously try to dominate the market, that their products are likely to be less effective in delivering what people want and that they will be trying to encourage dual use rather than cessation because they make more profit from combustible tobacco products.

Simon Clark: I am not here to represent the tobacco industry but I think that it is a load of nonsense that the industry would produce a product that nobody wants. What a load of nonsense! Look at it this way—the tobacco companies have a lot of money to put into research and development. E-cigarettes will get better and better. Looking at it from the outside, I would have thought that nobody is in a better position to pour money into research and development than the large tobacco companies. However, as I say, I am not here to defend them.

On Richard Simpson's initial point, the implication of what he was saying is that we should live in a risk-free world. We do not live in a risk-free world. The important thing is to give the consumer as much information as possible about the health risks of tobacco, e-cigarettes or any other consumer product.

Ultimately, it comes down to a word that Linda Bauld used earlier—choice. Let the consumer make an informed choice based on all the available information. It is their choice; it should not be the choice of politicians to decide how people are going to live their lives.

The Convener: That is us told.

Dennis Robertson (Aberdeenshire West) (SNP): As a politician who is concerned about the health and wellbeing of everyone in our society, I ask the witnesses whether they think that the bill strikes the right balance. Is there enough in the bill to allow the exemptions to be flexible enough? For example, could health boards designate areas as smoking areas because that is seen as the preferred route for certain patients' health and wellbeing, albeit with them perhaps going through a cessation programme? It may be that due to mental illness, psychiatric conditions or whatever, it is felt that we need those specific areas in health board premises.

Do you think that the enforcement aspect that we are talking about is proportionate? Perhaps enforcement can sometimes be overzealous. Do you have any points to make with reference to the policy enforcement and information aspect that Professor Bauld mentioned?

Professor Bauld: I feel more strongly about the e-cigarette elements of the bill and more able to speak about the evidence on that than on the hospital grounds issue, which—as I said earlier—is tricky and complex.

The principle of a smoke-free area around a hospital is important, as is the power to enforce it effectively, which is what the bill tries to do. I state again that the drafting of the regulations around that aspect will be crucial in getting the balance right.

Dennis Robertson: The issue is complex, but if it is determined that certain patients should be permitted to continue to smoke, in the interests of their overall health and wellbeing, should there be a designated smoking area? I am talking mainly about people who have significant mental health issues or psychiatric conditions.

Sheila Duffy: I cannot see that it could ever be argued that smoking tobacco is in the interests of anyone's health. We need to look at what smoking is doing for that person and what can be offered instead. For example, in the case of patients with mental health issues, some form of NVP might be an acceptable alternative, as it has been for a number of smokers.

11:15

Simon Clark: With respect, we are talking about wellbeing rather than health, and a lot of patients' immediate wellbeing may be helped by their being allowed to have a cigarette outside a hospital, whether it is a psychiatric hospital or a standard NHS hospital. I cannot repeat enough that I think that it is petty, vindictive and inhumane to say to people, "No, you cannot have a cigarette anywhere on hospital grounds". That is totally and utterly wrong, and it is where the bill goes too far.

Dennis Robertson: Do you think that we would have the appropriate guidance and information to enable enforcement officers to carry out their duties within hospital grounds?

Simon Clark: The problem is that enforcement will cost money. Hospitals may have to employ tobacco control wardens and put in closed-circuit television cameras. We have even heard of some hospitals putting in a sound system so that if the CCTV camera catches somebody lighting up in the bushes, a big voice comes out of the ether and says, "Put that cigarette out!" That is surely a ridiculous way in which to run a hospital. Surely hospitals have far better things to do.

Populus recently conducted a poll for us in which we asked people what their priorities were for hospitals, and tackling smoking came last in a list of 10 issues. Other issues were far more important to the public, such as reducing accident and emergency waiting times, reducing general waiting times and having more doctors and nurses. Those issues are far more important than whether somebody lights up a cigarette on hospital grounds.

Another problem with enforcement is that, if smoking on hospital grounds is made a statutory offence and somebody tries to stop somebody smoking on hospital grounds, what are they going to do? If it is a visitor, they can be ordered off the premises; if it is a patient, what is going to happen? Are they going to be ordered off the premises? Can they be manhandled? We would get into very difficult areas. If someone tried to physically stop somebody smoking on hospital grounds, that could be seen as assault. Let us be careful not to go down a very dangerous route.

Professor Bauld: NHS boards in Scotland have already taken the unanimous decision to make their grounds smoke free, in line with the Scottish Government's previous tobacco control strategy, which contained that objective. The bill tries to provide the basis for enforcing that by giving the boards' voluntary decision teeth. That is my understanding of the spirit of the bill. A number of countries outside the UK have successfully implemented smoke-free hospital grounds, and we could learn a great deal from them.

The Convener: What are those countries?

Professor Bauld: In respect of both prisons and hospitals, Canada provides a good example. Some states in Australia and parts of Scandinavia also provide good examples of smoke-free hospitals and hospital grounds.

Sheila Duffy: YouGov polling that we commissioned last year showed that 73 per cent of Scottish adults supported the proposal that smoking on hospital grounds should end.

Richard Lyle: Mr Clark, I would like you to stay back on this one so that I can hear from the other three witnesses. Can we get real on the bill? I agree that people should not smoke outside a hospital; nor should people litter the place or crowd. Sometimes, at 4 o'clock, when you are trying to get in to visit a loved one, you have to get by people who are standing there, puffing away. However, there may be a flaw or an opportunity in the bill. The Scottish Government writes in its policy memorandum to the bill that it will ban smoking "around buildings" but will allow

exceptions to the ban to be made in regulations. It states that that option complements

"existing smoke-free policies while taking a balanced, more realistic and more compassionate and safe approach".

I am a smoker, and I agree that people should not smoke outside hospitals but—this is the point that Mr Clark has been quite forceful on—should we not allow people to smoke beyond a 100 to 200-yard radius of the hospital entrance?

If I go into the car park at the Wishaw hospital—my wife does not want me to do this, by the way, so I do not do it now—I could smoke in my car and you could not do anything about that. I would be within the curtilage of the hospital grounds but in my own car, so let us not even go there. We could impose a ban within a 100-yard, 200-yard or 300-yard radius but, as the professor has pointed out, there are notices up in hospital grounds saying, "Don't smoke", and they are totally ignored. I want both sides to respect the fact that some people still want to smoke and some people do not. To ensure that smokers do not crowd around an entrance and respect others who use that entrance, we should have a designated area where people can exercise their human right—let us be honest about it—to do as they wish and have a cigarette, although I am not suggesting that we should spend money on putting up a shelter.

I know what Mr Clark would say—and he would say it for half an hour—but I have gone on for long enough, and I would like the three witnesses to comment. Should we not have a 200-yard radius and let people smoke outside that?

Sheila Duffy: The call for smoke-free hospital grounds and the policy on smoke-free hospital grounds did not come from my organisation, ASH Scotland. It came from hospitals and clinicians who have seen the pain caused to people's lives and families by diseases caused by tobacco. The magnitude of that epidemic, which is responsible for the early death of some 13,000 adults in Scotland every year, should not be underestimated. To me, it seems that the enforcement of a defined perimeter will address some of the concerns that Mr Lyle has raised and is a good starting point. The danger in creating areas for smoking is that you would be seen as acknowledging and permitting something that is damaging to people's lives.

The Convener: Would anyone else like to comment?

Andy Morrison: I would rather not talk about smoking, to be quite honest.

Richard Lyle: Again, I have to get real. One in three people will get cancer. As I said earlier, I smoke, but I have had a lot of friends who have died of cancer who have never smoked. I want to see the bill work and I want to ensure that what is happening in hospitals does not prevent that, but we have to get real. If I walk down Sauchiehall Street and drop my cigarette end, I could face a £60 fine—or it may have gone up to £80 now—and I accept that. However, I know from my two and a half years of working for the NHS out-of-hours service that, if you go to hospital to visit someone, you will see people coming out of the hospital crying because their loved one has just died, and the first thing they do is open their cigarette packet, shaking, and have a cigarette to calm themselves down.

If we are saying that we are anti-smoking, let us do away with smoking and let us lose the millions of pounds that the Government gets in tax. If we want to do away with smoking, let us do away with smoking, but we have to get real. We have to convince people. We had to convince people not to smoke inside premises, and they now accept that. We have got to—

The Convener: We have got to get to the question. The question that we seem to be focusing on is enforcement. We already have health board policies on this that are being ignored. We have public revulsion, not just from the clinicians who are treating people who are ill as a consequence of a lifetime of smoking but from people who are visiting hospitals and having to run the gauntlet of people smoking at the entrances to our hospitals. That is what my casework reflects, and we have a Government bill that seeks to address that.

Are we going too far by fining people who smoke in hospital grounds or in areas where they are clearly not allowed to? Should we be fining them on the spot?

Professor Bauld: To come back to the point that I made earlier, there is no point in having the current restrictions if they do not work. It makes a mockery of the time, money and effort spent on signage and everything else. As Sheila Duffy said, the push for the policy has come from clinicians and others who do not want a big group of people smoking around the periphery of the building, or the litter and all the other things associated with that. By having at least some of the hospital grounds covered by a smoke-free policy that is enforceable and has penalties associated with it, we can successfully implement that.

That is the spirit of the proposal. However, the detail of how big the perimeter should be and exactly what that involves is an issue for the regulations, and I do not think that it is straightforward.

The Convener: The other side is that I notice at hospitals, just as I do sometimes at pubs and clubs, that people are smoking outside the

building; they have not stopped smoking. I see staff members on the street outside the hospital perimeter having a cigarette before they go into work and I come back to the question of how we deal with that. As well as the punitive measures that there are, because those staff certainly face punitive action if they smoke on hospital grounds—they can be disciplined or dismissed—Professor Bauld mentioned earlier the gap in the support that health boards give to staff members and, indeed, patients who are in for a short or medium term, in telling them about the alternatives that can be given to support them when they have an addiction.

Professor Bauld: There is NICE guidance on smoking cessation in acute mental health and maternity hospitals, which does not directly apply to Scotland. My understanding is that the pathway that the guidance recommends is not widely implemented in Scotland. There is much more that could be done to give people other products, such as nicotine-containing products, to help them to deal with withdrawal. They should be able to use those products, if they want, when they go outside. Those are licensed products and there is much more that we could do. I also think that there is a place for NVPs. That is why it is so important not to ban nicotine e-cigarette use on NHS grounds, because an alternative for a staff member is not just a nicotine patch but an e-cigarette. Those alternative products and the support are crucial.

The Convener: Are there any other questions for our witnesses?

Mike MacKenzie: I was hoping to get to this point earlier. It seems to me to be fundamental to the question that the legislation is trying to address. Is there any evidence to suggest that passive smoking in the open air presents a tangible health risk?

Professor Bauld: Not for someone who is far away from the smoker. In close proximity to the smoker there will be the side-stream drift that there is indoors. That is why we do not want any environments, including some outdoor environments, where people are close to smokers and can be impacted by the side-stream drift, which is important.

Simon Clark: I am not aware that there is any evidence that lighting up in the open air is harmful to anybody even if they are standing quite close to the smoker. As soon as someone lights up in the open air, the smoke is massively diluted. Even a tiny bit of wind is going to blow it away.

I think that people are now very precious about walking past somebody in the street if they are smoking a cigarette. Quite often, it is not the smoke that is bothering people but the smell. We cannot go around banning things because we do not like the smell of them. Since the smoking ban came in, people have become very sensitive to even a whiff of smoke in a way that they were not before because they were used to it.

Now, people complain if they have to run the gauntlet of going past smokers outside hospitals. I agree with Richard Lyle that we should not have people smoking directly outside the entrance to a hospital, but when people use terms such as "running the gauntlet" of people smoking outside, I do not know what world they are living in. I am a non-smoker—I have never smoked—and, honestly, in my average day now, I cannot think of when I am exposed to somebody lighting a cigarette in the open air. If I am walking down the street, I am not even aware that they are smoking, or if I was, I could just move round them. It is complete and utter nonsense.

For anyone who is on their feet and mobile, I really do not see what the problem is. I understand why smoking is banned in outdoor stadiums, because if you are in a seat, you cannot move. Even though you are in the open air it is not very pleasant being stuck right next to somebody who is smoking. That would go for vaping as well—somebody having clouds of vapour blown into their face. However, on an open concourse at a sports stadium you can move.

Mike MacKenzie: We are getting the point, Mr Clark.

11:30

Sheila Duffy: Exposure to tobacco smoke would not be the main argument in this case. There are limited examples—where there is no airflow or where there are open windows and smoke drifts in—in which it could be a concern.

Simon Clark: I have heard the argument about smoke drifting in through windows being used a lot. I have not been in a hospital ward when somebody has been smoking outside, but I have been in a hotel when people have been standing outside smoking. The problem was not smoke drifting into my window but the people chatting too loudly so that I could hardly get to sleep. I am sorry, but the idea that smoke is drifting into people's windows when others are smoking outside is just hyperbole.

The Convener: It upsets some people. I have had casework about people smoking below the windows of seriously ill children at the sick kids hospital in Glasgow—they might have been chatting as well—and smoke going in the windows, so people are affected at different levels. I throw that in as an example.

Professor Bauld: I agree with Sheila Duffy that the main rationale for smoke-free grounds is not

health harm from second-hand smoke in outdoor areas, but there are studies that consider, for example, drift of smoke between an outdoor smoking area and an outdoor eating area. Researchers have been able to measure whether people are exposed to smoke when they are in close proximity to the outdoor smoking area. There is some data and it happens. However, the main arguments are not so much about the health harm as they are about taking tobacco out of society, creating less visibility and children's exposure.

Dr Simpson: Beer gardens have been researched in Australia. Anyone who walks from Waverley station to the Parliament has to go through a cloud of smoke within 20 yards of the station every morning. I have to say, Mr Clark, that if someone is an asthmatic, it is not the smell but the smoke that causes problems. Your arguments are overly strong.

Mike MacKenzie: I accept that, in certain circumstances, there will be a health argument to be made about passive smoking if it is concentrated. Dr Simpson mentions walking down from Waverley station. Vehicles have been largely excluded from that station because of the air quality, which is a problem in Edinburgh in general. I am interested in a scientific, risk-based approach to the matter. Perhaps Sheila Duffy can tell me how her concerns about the health risks from passive smoking in the open air compare with the health risks from the poor air quality in many of our cities as a result of traffic fumes so that we can get a sense of proportion on the issue.

Sheila Duffy: There are specific examples—for example, Victoria hospital—in which the windows tilted and, when people smoked directly outside by the building, the smoke went into the maternity ward. If you are asking me about vehicle pollution, I am aware of a study that compares vehicle exhaust with tobacco smoke, but I will have to look up the details and send it to the committee.

Mike MacKenzie: That would be interesting.

The Convener: The bill, of course, does not propose to ban smoking in open public areas.

Richard Lyle: Not yet.

The Convener: "Not yet," I hear from the heckler beside me, but we will see. There is a lot of revisionism going on this morning.

There are no other questions from the committee, so I extend the committee's thanks to the witnesses for attending, for the time that they have given and for their oral and written evidence.

As previously decided, we now go into private.

11:34

Meeting continued in private until 12:51.

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