Figure 1 Average concentrations of indoor air pollutants at locations in Chicago and New York.

Personal Aerosol Monitor (TSI, Inc, St Paul, Minnesota) to assess respirable suspended particles (RSPs). Cigarettes are major sources of small RSPs (less than 2.5 µm in diameter (PM_{2.5})). A review by the US Environmental Protection Agency indicates that PM_{2.5} exposure in excess of 65 µg/m³ in any given day is harmful to health.¹

Five air monitoring teams made measurements in 37 venues in and around the Chicago convention area on Wednesday (4 May) and Thursday (5 May) nights, between 6 pm and 12 midnight, for an average of 44 minutes in each venue. Research teams visited venues for at least 30 minutes with an aerosol monitor placed in a shoulder bag with a small tube protruding to sample the air. Additionally, three observations were made every 15 minutes in each establishment to assess the number of people present, the number of burning cigarettes, and the volume of the room using a Zircon DM S50 Sonic Measure. Average PM_{2.5} concentrations (128 µg/m³) in smoking establishments were six times higher than concentrations (21 µg/m³) in smoke-free establishments (fig 1). These data confirm the obvious—that Chicago area hospitality workers were being exposed to unsafe levels of indoor air pollution while working.

The organisers of the National Conference on Tobacco or Health have finally made the commitment not to hold another one of their meetings in a city that allows indoor smoking in public places. The next World Conference on Tobacco or Health has selected Washington DC for its 2006 meeting. When the venue was chosen in 2003 the host organisers, the American Cancer Society, believed that the nation's capital would be smoke-free, but as the date approaches, it remains to be seen if DC officials will enact a smoke-free air law in time for the conference. It is time for all health organisations to join together to use their collective financial clout to promote smoke-free cities when they plan their convention sites. Annual meetings of organisations such as the American Medical Association, American Cancer Society, and the American Public Health Association (APHA) bring valuable income to host cities. The 2004 International Association of Convention & Visitor Bureaus estimates direct spending to local economies per event to include US\$945 per delegate, \$6753 per exhibiting company, and \$454 673 per event

organiser.² Using these estimates, for example, APHA's 2004 meeting attended by 14 000 professionals contributed over \$13 million to Washington DC's local economy in delegate spending alone. When planning annual meetings, there are ample large cities that are smoke-free to choose from (for example, Boston, New York, San Francisco, Los Angeles, Honolulu, Providence, San Diego) with others soon to follow. The same is true globally with the number of world class smoke-free cities (for example, Dublin, Rome, Oslo, Auckland). It is time for all health organisations to put their money where their mouth is and make secondhand smoke history.

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Seasonal variations in stage of change among Quitline clients

Telephone counselling is an effective smoking cessation intervention and over the past decade smoking cessation quitlines have rapidly proliferated across North America, Europe, Asia, and elsewhere.¹⁻⁸ Despite the increase in quitlines, the published data are limited and tend to focus on call volume,

demographic breakdown of callers, and/or overall abstinence rates.¹⁻⁶ Numerous factors, including but not limited to dependence, self efficacy, and stage of change, are predictive of quit attempts and abstinence. Recent research suggests that cigarette smoking behaviours have a strong seasonal component,⁹⁻¹¹ with higher consumption and initiation in summer months and lower consumption and higher cessation in winter months. Possible reasons include—but are not limited to—the effect of weather, New Year resolutions, vacations, and tax increases.⁹⁻¹⁰

A better understanding of seasonality and smoking may be important for those planning, promoting, and evaluating smoking cessation services. We explored whether seasonality was related to stage of change among smokers who called NJQuitline, a state sponsored service in New Jersey, USA. Between 2002 and 2004, 4346 individuals desiring counselling called NJQuitline. During the initial assessment, callers' "stage of change" was classified as follows: contemplation (planning to quit within six months), preparation (planning to quit next month), action (quit for less than six months), and maintenance (quit for six months or more). Upon enrolment, 1% reported they were in maintenance, 16% had recently quit smoking and were in the action stage, 71% were in preparation, and 13% were contemplative. It is common for a relatively high proportion of new users of telephone quitlines, as well as internet smoking cessation, to have already quit when they seek support.¹⁻¹² Indeed, in the present study, 16% of enrollees were in the action stage and had quit before calling. However, the proportion of those in the action stage varied over the year (fig 1). A fairly consistent pattern emerges across all three years; a higher proportion of enrollees reported being in the action stage in January, July, August, and December (18.9%, 17.2%, 20.0%, and 19.3% overall compared with 14.6% during the rest of the year). The findings indicate that among those who sought support from NJQuitline, stage of change was impacted by seasonal factors. These possible seasonal factors deserve discussion. The high proportion of clients in the action stage in January and December (winter months in the USA) is likely attributable to New Years resolutions and clean indoor air restrictions.⁹ The increases in July and August are likely explained by cigarette excise tax increases—New Jersey raised its cigarette excise tax in July for each of the years presented. Lastly, as shown in fig 1, there were other months with a higher proportion of clients in the action stage, some of these months (November 2002, March 2002, March 2003) correspond with paid state sponsored media campaigns⁴⁻⁷ which are tagged with the NJQuitline phone number.

Quitline administrators are familiar with the large increases in call volume that occur following media advertising, and according to the season. This study suggests that there are also important seasonal effects on caller stage of change and smoking status. These seasonal differences should be borne in mind when planning, promoting, and evaluating telephone quitlines.

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Figure 1 Percentage of NJQuitline clients in "action" stage at enrolment: 2002–2004.

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Is there public support for banning smoking in motor vehicles?

In Australia and elsewhere, the evidence on adverse health effects of environmental

tobacco smoke (ETS) has resulted in legislation restricting smoking in enclosed public places and most workplaces. While there is considerable momentum to restrict smoking voluntarily in Australian homes,¹ adults and children continue to be exposed to ETS in motor vehicles.^{2,3} Advocacy to promote smoke-free cars when children are on board began at least as far back as 1994 in Australia,⁴ and in 1995 the Australian National Health and Medical Research Council recommended such a ban.⁵ Attention to this issue has increased recently following calls by the Australian Medical Association Western Australia, with an increasingly favourable view of bans in the media. Enforcement of legislation banning smoking in vehicles would be far easier than enforcing such legislation in homes, following precedents such as the policing of seat belt, baby restraints, and mobile phone use in cars. Banning smoking in vehicles is justified not only from a health perspective, but also from a road safety perspective as smoking is associated with increased risk of motor vehicle injury and death.^{6–8}

To assess Western Australians' support for banning smoking in vehicles, data were collected from Perth metropolitan residents aged 25–54 years who participated in surveys evaluating the impact of anti-tobacco campaigns. Interviews were conducted via computer assisted telephone interviewing, using random digit dialling to select households. The sample consisted of 205 non-smokers and 200 smokers/recent quitters.

Respondents were asked whether, if supported by a public education campaign, they were in favour of, against, or had no opinion either way for: (1) banning smoking in vehicles when children under 18 years are in the vehicle; (2) banning smoking in vehicles when there are any passengers in the vehicle; and (3) a total ban on smoking in vehicles.

There was strong support for banning smoking in vehicles when children under 18 are present, and this was significantly higher than for "any passengers" in the vehicle (smokers: 80% v 42%, $p = 0.000$; non-smokers: 87% v 62%, $p = 0.000$). Support for a total ban on smoking in vehicles was 24% among smokers and 49% among non-smokers ($p = 0.000$).

Data in this study and others^{9,10} suggest that bans on smoking in vehicles are likely to gain community support when applied to children under 18 being present in the vehicle. It will be interesting to observe

whether support for any form of ban increases as the community adapts to further restrictions on smoking in public places. While educational approaches are important, legislative options are worthy of consideration and debate.

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Health consequences of smoking 1–4 cigarettes per day: response to G F Cope (eletter to journal)

We thank Dr Graham F Cope for his valuable remarks, and agree that underreporting of daily cigarette consumption might be of importance when assessing the risk in light smokers.¹

Dr Cope refers to two papers: a cross sectional randomised study on smoking reduction in pregnant women, and an assessment of smoking status in patients with peripheral arterial disease.^{2,3} Our study did not concentrate on subgroups in need of regular medical attention; it covered all residents aged 35–49 years, except people with a history or symptoms indicating cardiovascular diseases (among them peripheral arterial disease) and diabetes.⁴ A general population in the 1970s may be less inclined to underreport consumption, than present day pregnant women and sick people, who do