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

Table 1 Dose-response between mean levels ($\mu\text{mol/l}$) of thiocyanate and reported number of cigarettes

Number of cigarettes per day	Males		Females	
	No.	Mean (SD)	No.	Mean (SD)
0	6212	33.9 (14.0)	7908	33.5 (14.2)
1-4	169	45.3 (18.4)	515	52.0 (22.0)
5-9	855	59.6 (20.7)	1661	70.9 (24.5)
10-14	1570	69.6 (22.2)	1800	81.5 (24.0)
15-19	1056	76.3 (23.1)	569	90.8 (25.5)
20-24	699	81.5 (26.4)	247	96.1 (25.6)
25+	235	87.3 (27.9)	36	99.7 (28.3)

not want to incur the disapproval of the healthcare professionals.

Based on a review and meta-analysis, Patrick and co-workers found that interviewer administered questionnaires, observational studies, reports by adults, and biochemical validation with cotinine plasma were associated with higher estimates of sensitivity and specificity.⁵ Our study compares favourably with these points: the study includes only adults, all questionnaires were checked by a nurse in an interviewer situation, and in one of the three counties, biochemical validation was carried out in all participants by determination of serum thiocyanate.⁶ Certainly, levels of thiocyanate may

be influenced by factors other than smoking; nevertheless, the dose-response between mean levels of thiocyanate and reported number of cigarettes is remarkable (table 1).

Finally, the attending persons reported their actual number of cigarettes per day in a special box in the questionnaire. Here they were allowed to give a range of daily consumption—for example, 10–15 cigarettes. In our analyses, however, we used the highest figure stated by the participant. Hence, a report of 3–6 cigarettes per day was categorised in the 5–9 cigarettes group.

We find it reasonable to conclude that the results presented in our paper reflect a marked increased risk in light smokers.

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