PostScript

LETTERS

Smoking brings another danger to children in Japan

The other day, I was walking in a crowded street near a subway station in Tokyo with my 7 year old son. He was so curious that he frequently stopped to look at something before running to catch up me. Predictably, he ran into a man who was walking and holding a lit cigarette which fell after their collision. I feared that the lit cigarette might hit my son in his face or eye. However, he did not sustain any injury because the cigarette only touched his hair.

In-street smoking while walking is becoming prevalent at most public places, including stations, workplaces, and schools, have become non-smoking zones. Smokers, prohibited from smoking in trains and stations, light cigarettes once they get to the street.¹ They are usually holding cigarettes at their chest or waist levels, equivalent to the face level of children or people in wheelchairs.

Lit cigarettes may cause facial or eye injuries and could cause blindness to toddlers.² Children can dart towards smokers while the smoker's attention is diverted from the cigarette. Not only do cigarettes cause chronic diseases but they also result in burns or as foreign bodies in natural orifices, especially among children. Tobacco products are the number one cause of poisoning among children under 5 years old in Japan, accounting for about 20%.³

In addition, lit cigarettes are also the leading cause of residential fire deaths in Japan, accounting for 19%.⁴ Fires not only damage people but also destroy houses, workplaces, and natural environments, resulting in a global burden physically, emotionally, and economically.⁵

More importantly, the threat of these injuries undermines our feeling of safety, even though their occurrence may be uncommon. Parents with children or people in wheelchairs are fearful of being injured in the streets and this may deter them from going out. As WHO notes, reducing injuries

or violence is not enough—subjective safety is also needed.⁶

Child outdoor or home environments are still not safe. Recently, several municipalities in Japan enacted a bylaw that bans smoking in crowded streets. The first was in the Chiyoda ward, a business center of Tokyo. To protect people from passive smoke, the Health Promotion Law was enacted in May 2003 but only covers indoor spaces. We need to persuade policymakers to expand such legislation. We also need to continue efforts to stop smoking in homes where children live.

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Intelligence, education, and transportation injury mortality

We read with interest the paper by Borrell and colleagues¹ in the June issue of *Injury Prevention* which reported on the relation between educational level and the risk of transportation injury mortality in nine European cohorts. An inverse association was reported in men but not women. We believe that findings from the field of cognitive (intelligence) epidemiology² may inform the discussions pertaining to the underlying mechanisms. Here, we define intelligence (denoted as IQ and assessed using written psychometric tests) as an individual's ability to learn, reason, and solve problems.

Recent reports of extended follow ups of individuals who sat intelligence tests in childhood reveal relations between IQ scores and later health outcomes, including total mortality, coronary heart disease, and

suicide. That is, people with lower IQ in early life experience a greater risk of these outcomes in adulthood.² For the most examined outcome—total mortality—the relation with early IQ is strong, incremental, and consistent across a number of study populations and research groups.² An inverse association between early adult IQ and later motor vehicle accident mortality in Australian Vietnam Army conscripts has also been found.³

Education and IQ are moderately strongly correlated; therefore, education may in part be a proxy for IQ. Some of the mechanisms that we have advanced to explain the associations between IQ and total mortality² may also have relevance to transportation injury mortality. First, IQ may be related to behaviors conducive to health which lie on the IQ-mortality pathway. For transportation injury mortality, such behaviors may include a greater use of protective devices (for example, cycle helmets, seat belts) in people with higher IQ scores. This relates to the "differential exposure" hypothesis advanced by Borrell *et al.*¹ Some support for this suggestion can be found in studies which show that individuals with higher educational attainment are more likely to wear cycle helmets than those with more basic qualifications.⁴ Second, information processing speed is a fundamental contributor to IQ differences, with which it is strongly correlated. An ability to process information rapidly and accurately is required in all forms of transportation, particularly those of higher speed such as car and motorbike use.

Whereas we are mindful of the maxim that "all findings can be explained by unmeasured confounding variables", we think that intelligence differences are worth considering at least as a partial explanation for the association between educational level and transportation injury mortality.

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When walking, smokers tend to hold cigarettes at the face level of children or people in wheelchairs. Photo: Michael Muir.

CALENDAR

13th Cochrane Colloquium

22–26 October 2005, Melbourne, Australia. The scientific programme will focus on several key issues affecting the Collaboration's work and contains a strong methodological component. Full details are available on the website www.colloquium.info

3rd New Zealand Injury Prevention Conference

2–4 November 2005, Wellington, New Zealand. Living and playing safely in Aotearoa New Zealand is the theme of this meeting. Visit www.ipn.org.nz for more information.

3rd (Canadian) National Conference on Injury Prevention and Control

6–8 November 2005, Halifax, Nova Scotia, Canada. The theme is evidence to action '05: injury, violence and suicide prevention. The

conference will focus on unintentional injury, violence, and suicide prevention and will highlight the latest science and best practices in policy and programs; actively bridge the gap between research and practice by highlighting specific policy and practice recommendations stemming from Canadian research and targeted research needs identified through community practice; encourage networking and collaboration between different sectors to promote action and policy change; facilitate participation from stakeholders representing vulnerable populations; and build momentum for sustained action from stakeholders at the municipal, regional, provincial, and national levels. For further information visit www.injurypreventionconference.ca.

2005 RoSPA Home Safety Congress: Reducing Risks and Injuries at Home

14–15 November 2005, Solihull, England. This year's event will share good practice of home risk assessment; report on current research projects; discuss ways of evaluating

home safety interventions; explore methods of collecting and disseminating home accident data; examine funding opportunities; and consider the best methods of reducing inequalities in health. Visit www.rospace.com/home/index.htm for further information.

2006 RoSPA Road Safety Congress: The Road to Safer Behaviour

27 February – 1 March 2006, Blackpool, England. Visit www.rospace.com/road/index.htm for further information.

8th World Conference on Injury Prevention and Safety Promotion

2–5 April 2006, Durban, South Africa. Further information and key dates visit www.safety2006.info.