website: www.gmc-uk.org/doctors/licensing/faq_revalidation.asp. Change also brings challenges of implementation, so the GMC is piloting and consulting extensively to ensure that systems work. Revalidation will start in 2011, but not in all specialties or in all parts of the UK at the same time. We will start only where and when we are ready, with progressive phasing-in over the ensuing two to three years.

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EDITORIALS

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Passive smoking and children's health

Linda Cuthbertson and John Britton

Two generations ago in the UK over half of all men, and nearly half of all women, were smokers. Offering a cigarette to a visitor or guest was considered polite. Government health ministers smoked at their desks. Smoking in public, at work or in the home was normal behaviour, and clouding of indoor environments with tobacco smoke was commonplace.

With the publication of the first reports by Doll and Hill on the association between tobacco and lung cancer, and particularly after the publication of the Royal College of Physicians (RCP) report (*Smoking and health*) in 1962, the prevalence of smoking began to fall but it remained widespread in public.[1–3] As time passed, however, increasing recognition that exposure to tobacco smoke in the atmosphere (variously referred to as passive smoking, environmental tobacco smoke and second-hand smoke) constituted a health hazard as well as a nuisance led to restrictions on smoking in a range of public places. By the year 2000 nearly half of the UK population worked in smoke-free environments, and the recent passage of smoke-free legislation throughout the UK now means that enclosed public and work places are required by law to be smoke free.[4] However, passive smoking remains a significant health hazard as a result of exposure in the home, which in 2003 caused nearly 11,000 deaths among adults in the UK.[5] The impact of second-hand smoke on the health of the approximately two million children who are currently exposed to passive smoke in the home, however, has not been established.

The 1992 RCP report *Smoking and the young* summarised the impacts of smoking on children at a time when much of the evidence of harm was still only just beginning to emerge.[6] A new report from the RCP, *Passive smoking and children*, has therefore been produced to review this evidence again, and to quantify the effect of second-hand smoke on children's health. There were two main drivers in producing the report – firstly, the need to update the epidemiological estimates of harm to children from passive smoking, including relative risks, hospital admissions and general practice (GP) attendances and, secondly, to identify policy areas to reduce exposure in the future. The new report presents systematic reviews and meta-analyses of the major health effects of passive smoking in children, and estimates that exposure causes about 20,000 cases of lower respiratory tract infections, 120,000 cases of middle ear disease, at least 22,000 cases of wheeze and asthma, 200 cases of bacterial meningitis and 40 sudden infant deaths in UK children each year. This burden of disease results in over 300,000 UK GP consultations, around 9,500 admissions to hospital each year, and a significant cost to the NHS – an estimated £9.7 million to primary care, £13.6 million on hospital admissions and £4 million on asthma drugs. It also estimates that around 23,000 children become regular smokers by the age of 15 as a result of exposure to smoking by their parents. The impact of this influence on the future health of these individuals is potentially catastrophic.

All of this morbidity and mortality, and cost to the NHS, is completely avoidable. Since most exposure of children to passive smoke occurs as a result of parental smoking in the home, there are two simple means of preventing exposure: firstly, to encourage as many parents as possible to quit smoking, and secondly, to encourage those who cannot or will not quit to make their homes smoke free. Unlike smoking in enclosed public places, however, smoking in the home cannot be prevented through legislation; instead, a comprehensive strategy is needed to reduce the prevalence of adult smoking and promote smoke-free homes.

Reducing smoking prevalence requires sustained increases in the real price of tobacco, further reduction in smuggling and

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illicit trade, sustained investment in mass media campaigns targeting parents and younger adults in general, more effective health warnings, prohibition of point of sale display, mandatory generic standardised packaging, provision of tailored cessation services, and a range of other policies. Smoke-free homes can be promoted through mass media campaigns, behavioural interventions, and possibly by substituting cigarettes with medicinal nicotine. However, perhaps most importantly, it is necessary to reduce still further the exposure of children to smoking behaviour as well as to tobacco smoke. This will require a radical rethink on where it is reasonable and acceptable for adults to smoke. It will also require further legislative measures to prevent exposure that does still occur outside the home, for example in private vehicles.

Children have a right to grow up in a safe environment, and parents and governments have a moral duty to provide one. Passive smoking, and smoking behaviour, is a major hazard to children's health. Although relatively neglected in the debate on smoking to date, it is time to prioritise the health and rights of children to grow up in a smokeless environment free from exposure from adult smoking role models. Attitudes to smoking in the UK have undergone a major shift in recent years, but there is still a long way to go. It is time for a new approach to safeguarding children from the hazards of tobacco smoke and tobacco smoking. Our children's health depends on it.

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