The children mentioned by Dr Raffles and Dr Stewart seem to have had problems whether they were on the ground or in the air, and close medical attention with personnel fully trained in infant and child intensive care was necessary. What was applicable in these children does not necessarily apply to most children with cyanotic heart disease.

G R CUMMING

Winnipeg Clinic,
Manitoba R3C 0N2

Women in prison

SIR,—Your series on the state of the prisons has helped in the important task of linking prison doctors with the mainstream of doctors. The importance of these doctors being guided by the same ethics and concern for their patients as the rest of us is highlighted by the problems in South Africa and the USSR, where doctors have been used to inflict repression and torture on people.

I was disappointed, however, in the article on women in prison (25 February, p 630) not to read more about the conditions of women in Armagh gaol in Northern Ireland. Since November 1982 every woman leaving and returning to the prison has been stripped naked and made to undergo a public visual body inspection by prison officers.[1] They are required to open their legs wide to allow an intimate inspection and to remove all sanitary protection. This applies to remand prisoners as well—that is, women innocent until proved guilty—and for them it is a frequent ordeal as it applies to all their court appearances and happens going both to and from the court. In addition, these women are being punished for very minor infringements of prison rules (themselves changed frequently) by periods of solitary confinement, loss of visits and food parcels, and loss of exercise time.

These sorts of conditions in a British gaol should not be ignored and condoned by doctors. The BMA has recently taken a firm stand on South Africa and should extend its ethical and humanitarian concern to putting our own prisons in order.

CHARLOTTE PATERSON

Martock, Somerset

[1] Toolis K. "The only point of a strip search is degradation." *Guardian* 1984;9 March:11.

Tobacco promotion

SIR,—The allegations about tobacco and advertising made by Mr Howard T Cox (28 January, p 303) are refuted not just by the tobacco industry but by the facts, which seem to be ignored by many who attack smoking.

Much has resulted—not "depressingly little"—in the 13 years of voluntary agreements, and these are not "so called" but properly negotiated. The agreements about the extent and content of cigarette advertising, and the codes laid down, have been met by the industry with consequent reductions in commercial freedom.

The attempt to rekindle the old argument that it is advertising which is responsible for determining demand is rejected by the industry. No serious research has been able to support that premise nor the vague argument about social acceptability. Advertising bans in a number of countries have failed to produce the results anticipated for them. For example, in Norway, where a total advertising ban has been in force for seven years, fully supported by the four WHO criteria cited by Mr Cox, there have been only minor fluctuations in demand, and those probably for other reasons.

The industry rejects the notion of voluntary agreements being supplanted by legislative bans on commercial freedom, particularly when the justification is merely token support for the antismoking movement.

The emphasis given to low tar brands is in response to the requirements of government acting on the advice of the independent scientific committee on smoking and health and is a commitment under the terms of a voluntary agreement with government.

The charge that agreements with the government lead to any lessening of competition in the market place is nonsense. It is not supported by the evidence of what has happened in the UK. There has obviously been no collusion to avoid competition. Nor has there merely been an "attempt" to stabilise expenditure on sports sponsorship; the ceiling is set by the voluntary agreement, and it is not exceeded.

All reasonable solutions, properly negotiated and agreed with successive governments, of course pre-empt the need for extremist legislation. The article dismisses the econometric argument on the basis of unpublished, unsubstantiated, and unexplained evidence, also by Mr Cox, and this scientifically speaking is surely not the most persuasive way to conclude an argument.

H B GRICE

Tobacco Advisory Council,
London SW1E 5AG

**Mr Cox replies below.—ED, *BMJ*.

SIR,—The views expressed by the Tobacco Advisory Council will come as no surprise to most doctors. Its contention that much has resulted from voluntary controls on advertising will strike many observers, conscious of the widespread encroachment of tobacco promotion into so many aspects of our culture through sponsorship, as a difficult proposition to endorse.

What it does serve to illustrate, however, is that the gulf separating the two tobacco lobbies is as wide as ever. It is a climate that affords little scope for dialogue, and I shall content myself with two distinct, but obviously related, criticisms of the system of voluntary controls, based on the available empirical evidence.

The review of previous econometric studies was presented not to dismiss the results but to highlight them. The failure of most of the previous econometric studies to isolate any clear relation between changes in the volume of advertising and the demand for cigarettes is not surprising. For a well established product such as tobacco variations in the volume of advertising through such mediums as posters and periodicals cannot produce the same immediate, predictable impact on consumer behaviour (beyond eliciting fluctuations in brand preference) that is associated with, for example, changes in price.

The effect of advertising on demand is both more subtle and durable. Moreover, given the current extensiveness of tobacco promotion activities it is plausible that appreciable reductions in advertising could be made without any perceptible effect on overall consumption. What the findings of earlier studies suggest, therefore, is that the impact on demand of the current voluntary reductions in conventional advertising will be negligible.

The difficulty with the existing econometric debate is that it provides no useful evidence on which to assess the impact of a total ban on tobacco advertising and promotion. Indeed, econometric modelling of such an event is exceedingly difficult—partly because of the uncertainty surrounding the time lags involved and partly because those countries which have enacted legislation have tended to include it as one of several measures aimed at undermining the social acceptability of smoking.

Given these difficulties, our study of smoking patterns in 15 Organisation for Economic Co-operation and Development countries has attempted to gauge the relative effectiveness of legislation versus voluntary controls by examining the underlying trend in consumption and the extent of fluctuations in demand, after allowing for those changes attributable to price and income effects.[1]

Our findings indicate that as a group countries with legislative controls (including Norway) exhibit a more pronounced negative trend in consumption and greater fluctuations in demand when compared with countries using voluntary controls. We believe that this comparative approach is the only relevant way to assess the effect of legislative controls on smoking behaviour, and it supports the hypothesis that legislation is a more effective way of influencing consumption than voluntary agreements.

HOWARD COX

Kingston Polytechnic,
Kingston upon Thames KT1 2EE

[1] Cox HT, Smith RP. Political approaches to smoking control: a comparative analysis. *Applied Economics* (in press).

Evaluation of a course on muscles and joints

SIR,—Having read Dr Alistair K Ross and Mr William A Lawton's paper (25 February, p 609) I conclude that audit has become a goal in itself for some doctors. The authors note that written test results improved after a course had been attended. This unsurprising result does not, however, relieve any patient's musculoskeletal pain. What matters is, "What practical good did the course do?"

To answer this question the authors collected data before and after the course, the significance of which is entirely unknown. For instance after the course there was a significant decrease in drug prescription. Were patients pleased with this? There was also less bandaging, compression, bed boards, cervical collars, etc. Did this mean no treatment or better treatment (or worse treatment)? There were a few more local injections and manipulations performed after the course, but with what result?

Surely it is of little use to observe that doctors' management of a wide range of conditions was slightly changed by a course? What one wants to know is if the new management is any better than the old.

N A WATSON

London W1M 7AE

**Dr Ross replies below.—ED, *BMJ*.

SIR,—Dr Watson's letter touches on the essence of medical education—that is, that its goal should be the improvement of patient care. There are, however, many factors and influences along that pathway that are beyond the control of the teacher or course organiser. In trying to measure cause and effect one has to take one step at a time.

I tried to measure the gain in factual knowledge and the changes in patient manage-

Br Med J (Clin Res Ed): first published as 10.1136/bmj.288.6423.1088-a on 7 April 1984. Downloaded from http://www.bmj.com/ on 19 April 2024 by guest. Protected by copyright.