

Health care has, he believes, been led on to a mistaken path by the belief that the body is a machine and that medicine should concern itself with identifying and correcting faults and defects when it goes wrong. This is the wrong concept: what we need to do is to identify and correct the external events that lead to the fault in the machine. With that switch in emphasis, medical research has much yet to offer. The wider view should also be extended to personal medicine, so that providing acute care should be seen as the beginning of a responsibility that continues so long as the patient remains unwell, and cutting across arbitrary distinctions—acute and chronic, mental and subnormal.

¹ McKeown, Thomas, *The Role of Medicine: Dream, mirage, or Nemesis?* The Rock Carling Fellowship 1976. London, Nuffield Provincial Hospitals Trust, 1976.

² Dubos, R, *The Mirage of Health*. London, Allen and Unwin, 1960.

³ Illich, I, *Medical Nemesis*. London, Calder and Boyars, 1975.

That lethal weed

Any doctor who has recently attended a medical committee meeting (and who has not these days) will have observed how few of his colleagues smoke. The opposite pattern is commonplace in works committees and even in academic meetings with non-medical members. After two hours the room is laden with tobacco fumes. Clearly, while the medical profession has got the message of the dangers from smoking and has taken it to heart, the general public has failed to heed the warnings contained in the reports by the Royal College of Physicians and the United States Public Health Service.

The paper by Doll and Peto in this issue (p 1525) brings to an end a 20-year investigation of doctors' smoking habits and sets out in detail the toll that smoking takes from human life, in both mortality and lingering ill-health. The ratio of the death rate among cigarette smokers to that among lifelong non-smokers of comparable age was, for men under 70, about 2 to 1, while for men over 70 it was about 1½ to 1. The investigators examined the evidence for many different causes of death, the relations with age and with tobacco consumption, and the effects of giving up smoking. The chief ways in which smoking causes death, especially in middle-aged men, are by heart disease, lung cancer, chronic obstructive lung disease, and various vascular diseases. Furthermore, smoking is a contributory causal factor in other conditions (sometimes fatal) such as peptic ulcer, cancer of the bladder, and hernia. These conclusions support other investigations, of which the most recent are the reports of Reid *et al*¹ on coronary heart disease in civil servants and Dische *et al*² on cancer of the bladder and lung.

Between 1951 and 1971 the average number of cigarettes smoked per day by doctors fell from 9.1 to 3.6, and this has contributed to a steady decrease in the incidence of lung cancer deaths in those aged under and over 65. The change is not so evident in chronic obstructive lung disease: there is probably permanent damage to lung tissue. Giving up smoking in a condition such as chronic bronchitis is likely to improve the disease symptomatically but the damage to the lung tissue remains. The higher incidence of deaths from the complications of hernia in smokers must undoubtedly be due to the extent to which a hernia can be aggravated by chronic cough.

This latest report by Doll and Peto consolidates and amplifies the mass of evidence that smoking is a most serious health

hazard and one which is preventable. Doctors as a group have improved their health expectation partly by younger ones not starting to smoke but mostly by older ones giving up smoking or reducing the number of cigarettes smoked. Why is it so difficult to induce the rest of the population to do the same?

Much has been done: measures include the Government warning on the cigarette packet, the publication of the tar content list, more non-smoking areas in public transport, and some vigorous health education efforts. A fresh offensive is needed. A summary of Doll and Peto's report should be made available to every doctor, schoolteacher, and others concerned with advising young people.

The best way for them to avoid the smoking danger is by not starting to smoke. Children of parents who are smokers have a greater tendency to smoke, and here there is a strong case for parental example. The time has come to make smoking unattractive and socially unacceptable. All too frequently the enjoyment of a non-smoker in a theatre or cinema is ruined by a nearby addict constantly enveloping him in a miasma of secondhand tobacco smoke. Surely smoking should be prohibited in theatres and cinemas. Other countries do this, with advantages to the audience and greater safety, and they also enforce non-smoking regulations much more effectively than does Britain—where all too often the comfort of many is destroyed by a selfish smoker ignoring the rules. Non-smoking areas in restaurants would be welcomed by many, and the Government warning printed on ashtrays would help to get the message across. The evidence is now so strong that the message on the packet should state that smoking "will" damage your health. There is a challenge for the Health Education Council with its new chairman and chief medical officer.

¹ Reid, D D, *et al*, *Lancet*, 1976, 2, 979.

² Dische, S, *et al*, *British Medical Journal*, 1976, 2, 1174.

Intranasal beclomethasone: wonder drug or hazard?

Whenever a new drug preparation becomes widely used there naturally arise fears as to its safety, especially when the drug is a corticosteroid and the disease for which it is used is minor. This has happened with the beclomethasone dipropionate aerosols, which have become so popular for treating rhinitis.

The chronic stuffy, runny nose may be a formidable problem for management. When surgical conditions and infections have been eliminated the diagnosis of exclusion is rhinitis, either allergic (extrinsic) or vasomotor (intrinsic). Though perennial allergic rhinitis may be difficult to differentiate from vasomotor conditions, patients with seasonal hay fever form a separate clinical group. Conventional treatment often gives unsatisfactory results, though desensitisation may help in definite cases of specific allergy. Antihistamines often cause unacceptable somnolence, and decongestant drops and sprays provide only transient relief with frequent severe rebound symptoms. Intranasal sodium cromoglycate is often ineffective. Perhaps better than drugs are simple measures such as hot drinks and avoiding smoking and other irritants, stress, and rapid changes of temperature.

The concept of administration of topical steroids to the mucous membranes of nose and bronchial tree is far from new.