LETTERS TO THE EDITOR

Letters intended for publication should be a maximum of 500 words, 10 references, and one table or figure, and should be sent to Simon Chapman, deputy editor, at the address given on the inside front cover. Those responding to articles or correspondence published in the journal should be received within six weeks of publication.

"The Tobacco Products Research Trust 1982–1996"

EDITOR,—Lisa Bero's review of the above report[1] is generous, but contains, apart from a number of minor inaccuracies, two specific points which we think should be challenged.

(1) *"More documentation of the futile search for a 'safer' cigarette".* The reviewer makes much of the fact that "internal tobacco company research . . . had already demonstrated by the early 1980s that the production of a safer cigarette was not feasible for a variety of practical and legal reasons." However this view was never apparent to the trust and only came into the public domain in the mid-1990s, when the trust's programme was terminating, with the delving into the Brown and Williamson papers.[2] She also discounts the points that (a) the search for a "safer" cigarette (after the collapse of tobacco substitutes) by "product modification" required properly funded and planned studies to monitor the programme's effectiveness (or lack of it) and this formed the basis of the constrained terms of reference of the trust; and (b) that the final industry decision on monies to the trust was made in 1984 (with the last agreed payment in 1987), well before the alleged discoveries by Brown and Williamson. The continuance of the trust until 1996 was due to the pace of the trust's agenda rather than to continued payments from the industry. The reviewer concedes that trust-sponsored studies showed an independent effect of tar yield on certain smoking-related diseases but surprisingly seems to consider that lower tar cigarettes, after discounting the effect of compensatory smoking, would not be "safer" than higher tar ones.

(2) *Independence of the trust from the tobacco industry*. The reviewer, by statement and innuendo, suggests that the trustees were not working free from the influence of the tobacco industry. This is not so. The trust was created by the Independent Scientific Committee on Smoking and Health (ISCSH) to administer research funds obtained from the tobacco industry (via the Tobacco Advisory Council (TAC)) for the Committee as part of the voluntary agreements (of 1980 and 1984) between government and the TAC which (to the reviewer's clear disappointment) did not obviously include research related to smoking prevention and cessation! The legal status of the trust and the independence and objectivity of the trustees ensured that the responsibilities were discharged at arms-length from specifically, but not exclusively, the contracting and interested parties—the tobacco industry and government.[3] The reviewer's statement that the "tobacco companies participated in meetings and advised the [Tobacco Working Group] on the direction of research, *just as they did for the [Tobacco Products Research Trust]*" (our italics) may have been true for the Tobacco Working Group, a federally supported initiative launched in 1973 by the National Cancer Institute in the United States, but is certainly not true for the trust.

CHERYL SWANN
Tobacco Products Research Trust
Keats House, 24–26 St Thomas Street,
London SE1 9RT, UK

PETER FROGGATT
Tobacco Products Research Trust

In reply,—(1) *More documentation of the futile search for a "safer" cigarette*. The key point in Cheryl Swann and Peter Froggatt's response to the contrast I make between internal tobacco company research and research funded by the trust is that the tobacco company research was not in the "public" domain until the 1990s. As I stated in my review,[1] the report on the trust, as well as Swann and Froggatt's response to the review, begs the question of why the tobacco industry was supporting research on a "safer" cigarette when it already knew that a cigarette that was both safe and addictive could not be developed for a number of legal and practical reasons. As described in the trust's own report, low-tar cigarettes are not "safer" than higher tar ones because smokers puff on them more frequently, increase the depth and duration of smoke inhalation, smoke more cigarettes per day, and smoke cigarettes to a shorter butt length.[1]

(2) *Independence of the trust from the tobacco industry*. I was disappointed that the entire £8 million spent by the trust was spent with the aim of maintaining use of a harmful product, rather than on prevention and cessation research that could potentially decrease use of a harmful product. The Tobacco Working Group is not identical to the trust. For example, as stated in my review, the Tobacco Working Group was not funded by tobacco companies.[1] However, there were striking similarities between the Tobacco Working Group in their research agendas (which were set by the tobacco companies) and non-traditional peer review processes.[4]

LISA A BERO
Institute for Health Policy Studies,
University of California at San Francisco,
1388 Sutter Street, 11th floor,
San Francisco, California 94109, USA.
bero@cardio.ucsf.edu

1 Bero L. More documentation of the futile search for a "safer" cigarette (book review). *Tobacco Control* 1997;**6**:250–1.
2 Glantz SA, Barnes DE, Bero L, *et al.* Looking through a keyhole at the tobacco industry: the Brown and Williamson documents. *JAMA* 1995;**274**:219–58.
3 Froggatt P. Support for UK biomedical research from tobacco industry. *Lancet* 1997;**349**:1329.
4 Glantz SA, Slade J, Bero L, *et al.* *The cigarette papers*. Berkeley, California: University of California Press, 1996:155–62.

Consultations for cervical smears in general practice: a missed opportunity for smoking cessation advice?

EDITOR,—Consultations in general practice in which cervical smears are performed typically include more than one problem per encounter.[1] Other than an earlier needs assessment involving consultations conducted by 23 trainees,[2] no Australian studies have examined the provision of health promotion advice during consultations scheduled for a cervical smear. As the risks of cervical intraepithelial neoplasia and cervical cancer are higher for women who smoke,[3] the provision of smoking cessation advice would be especially opportune in these consultations.

We invited general practitioners (GPs) in urban Sydney to register for a comprehensive quality assurance programme in cervical screening.[4] As part of this program, each GP was provided with 20 consent forms and asked to approach a consecutive sample of women attending for a cervical smear to complete a follow-up survey. Women so agreeing returned a signed consent form to us directly and, upon receipt, we forwarded a nine-page questionnaire which included questions about the woman's smoking status and her recall of smoking cessation advice during the consultation. Fourteen days after the initial questionnaire mailing, non-respondents were sent a reminder letter. Any remaining non-respondents were telephoned on day 35 and asked to return their questionnaire.

Of 142 self-selecting GPs participating in the programme, 94 (66%) were female and 112 (79%) worked full-time. We received consent forms from 2297 women attending for a smear, of whom 2050 (89%) returned completed questionnaires (number per GP ranged from two to 20; median = 16; mode = 18). Of these, 477 (23.4%, 95% confidence interval = 21.6% to 25.2%) women were smokers. The provision of smoking cessation advice in consultations for a cervical smear was low (table). Smoking cessation advice was significantly more likely to be given to older women ($\chi^2 = 5.4$; df = 1; p for trend <0.001). There was no association between GP sex and the provision of smoking cessation advice, however ($\chi^2 = 2.7$; df = 1; p = 0.1).

Our findings are cause for concern. Other studies have persistently demonstrated low rates of smoking cessation advice.[5–7] As just over a third of smokers recalled being advised to quit, opportunities to provide such advice in consultations for cervical screening also are being missed. Although the representativeness of our self-selecting sample of GPs is unknown, it appears we have failed to engage all GPs in a concerted public health effort against tobacco, even within the context of a

Smoking status and general practitioner advice about smoking (n = 2050)

	n	*%*	*(95% CI)†*
Women asked smoking status (n = 2030)*	608	30.0	(28.0–31.9)
Total who smoke at all (n = 2040)*	477	23.4	(21.6–25.2)
Smokers asked smoking status (n = 477)	200	41.9	(37.5–46.3)
Smokers who recalled being advised to stop smoking (n = 477)	161	34.0	(29.8–38.3)

*Denominators vary due to missing data.
†Adjusted for clustering within GPs using STATA statistical package.
CI = confidence intervals.