Progress on smoking control in Western Australia

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In 1990, 20 years of campaigning by the Western Australian branch of the Australian Council on Smoking and Health succeeded in getting tobacco advertising banned in Western Australia and a fund set up to replace the sponsorship of sport by tobacco companies. The council coordinated the activities of the mainly professional medical organisations that formed its members, ensuring that messages about the dangers of tobacco were consistently presented from different angles. The campaigners also ensured that medical data were reworked for presentation to decision makers and public, invaded the corporate world, and minimised opposition by enlisting the support of sportspeople opposed to tobacco sponsorship. The council hopes now that elimination of advertising will reduce the prevalence of smoking.

In 1990 the parliament of Western Australia passed a law to ban tobacco avertising. This legislation came after two failed attempts in the early 1980s and after 20 years of campaigning by the Australian Council on Smoking and Health. Thus the David and Goliath contest between tobacco and health ended in victory for David—as we predicted in 1985.[1] The battle was not easy, however, and lessons learned during our conflict in Western Australia may be useful to groups in other countries trying to achieve similar victories.

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Background

The first Western Australian statute applied to tobacco was a 1911 law which prohibited smoking in cinemas and theatres. Six years later the Tobacco Act of 1917 made the sale or supply of cigarettes to children under 18 years illegal. There were then no new controls on tobacco in Western Australia for another 55 years.

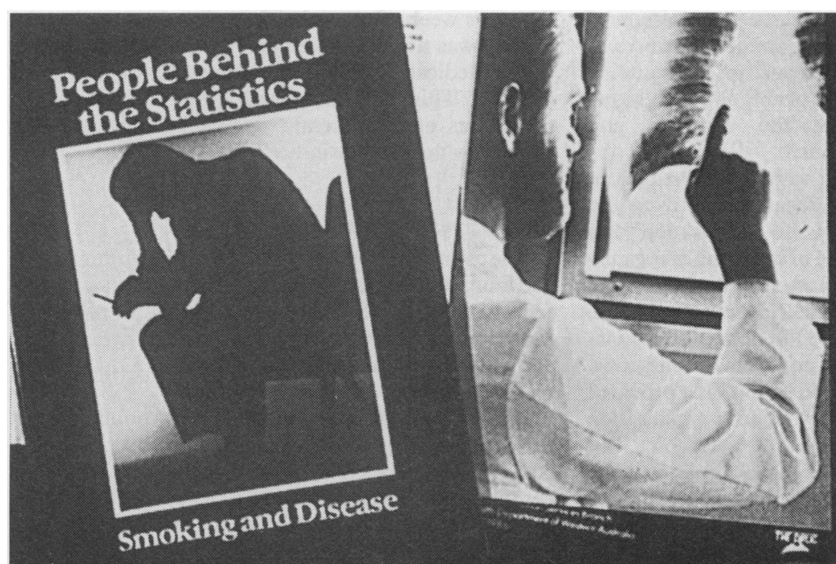
Following the increasing awareness about the harmfulness of smoking the issue of controlling tobacco use has been high on the public health agenda in Australia. In 1967 the Australian Council on Smoking and Health was established. In 1972 health warnings on cigarette packets became mandatory throughout Australia.[2] Other legislation included a federal ban on cigarette advertising on the electronic media (1976), revised health warnings on cigarette packs (1987), and a ban on smoking on all domestic airline flights (1987).[2] Until 1990, however, tobacco advertising was permitted virtually anywhere, and certainly in newspapers and magazines and on billboards. In 1990 not only did Western Australia prohibit tobacco advertising; federal legislation banning tobacco advertisements in the print media also came into effect.

In 1978 the Western Australian office of the Australian Council on Smoking and Health took over the functions of the national organisation from New South Wales. The council confirmed its aim of seeking a ban on cigarette advertising and in 1979 formed a legislation committee to coordinate the drafting of a parliamentary bill.[1]

Modelled on legislation in Singapore and Norway, the Tobacco Products Advertising Bill was introduced into, but failed to pass through, the state parliament in both 1982 and 1983. The main opposition came from sporting bodies because of concerns about future sponsorship but also possibly because of loyalty "bought" through previous sponsorship. The issue of sports sponsorship remained one of the major impediments to legislation in the following years.

In the meantime—possibly as a result of exposure to health campaigns—the government increased the state tobacco tax, and $2m a year from this tax was allocated to establish a smoking and health programme within the public health department of Western Australia.[1] This initiative was supported by the opposition parties (who had opposed an advertising ban), and there was widespread support for the "quit" campaigns to reduce smoking rates. In 1984 the Labor Premier Brian Burke said that he would not introduce anti-tobacco legislation before the next state election. Once the Labor government was returned in 1986 the council re-established its legislation committee with the aim of encouraging the government to initiate legislation.

By 1988, however, with another state election approaching, the council realised that the government was not going to introduce the legislation into the current Parliament. It then formed a strong alliance with the Australian Medical Association and launched many campaigns. These campaigns, along with the residual support for legislation to phase out cigarette advertising from the 1982 and 1983 legislation attempts, meant that there was increasing support within parliament for such legislation. At the same time support was enlisted from the National party,



Reworking research data into new forms is a fundamental task of all campaigners: "People behind the Statistics" was written by the council and published by the health department of Western Australia

which traditionally forms a coalition with the Liberal party when in government. The spokesperson for health in the National party, general practitioner Dr Hilda Turnbull, was committed to smoking control measures. After intense debate within her party a resolution was passed at its 1989 state conference "That all mediums of tobacco advertising be banned" (C Varvell, personal communication, 1991). Next, a media campaign was combined with letters and deputations to every member of parliament. On 24 August 1989 the Labor premier, Peter Dowding, announced that he would introduce legislation to ban tobacco advertising and establish a health promotion foundation from tobacco taxes which would buy out tobacco sponsorship of sporting bodies .

Intense lobbying continued throughout the passage of the legislation, and the bill's passage was delayed. Nevertheless, in December 1990 it passed with only token opposition from conservative stalwarts on the last day of sitting of the Western Australian parliament.

Although the Australian Council on Smoking and Health could not claim total credit for the legislation, the part it played in the 20 years leading up to this success—and the way it played it—was critical to the change of heart of legislators in the state.

Lesson one: identify realistic objectives and priorities

The commitment of several professional medical bodies and individual doctors led to the formation of the Australian Council on Smoking and Health (Western Australia) in 1971. The Council's "inaugural goals" were the labelling of cigarette packets with tar and nicotine levels; the reduction of smoking on public transport and in other public places; encouraging doctors, nurses, public health workers, and parents to set an example by not smoking; encouraging research; and political action. The need for legislation to control tobacco advertising and marketing was also identified as a high priority at this early stage. These goals were seen as being realistic and achievable, although 20 years elapsed between setting the last of these goals and achieving a positive result.

Lesson two: coordinate professional networks

The major strength of the Australian Council on Smoking and Health has been the commitment to the single issue of smoking of a large number of reputable and conventional professional organisations (listed in the acknowledgements). These organisations' nominees formed a core of regular council members. A modest amount of government and private funding allowed for a small full time staff of able and committed professionals to complement the expertise and execute the decisions of the council.

Winning entry in the "Cough up an ad" competition 1987, from Nathalie Maron, aged 14

An organisation with such a wide membership can create a critical mass of energy, ideas, and activity; and a key function of this "single issue organisation" has been to coordinate the activities of its member organisations. Publicity on the effects of cigarette advertising from groups such as the National Heart Foundation, the Cancer Foundation, and the Public Health Association as well as the royal colleges of surgeons, physicians, and general practitioners not only provided a consistent message. It also allowed each organisation to elaborate on different aspects of the topic. The overall effect was a perception of smoking as an issue that concerned the general medical and health community rather than just one single purpose organisation. In addition, academic professional associations such as the Thoracic Society of Australia actively supported the council. Their internal support for tobacco legislation through policy and practice (such as not permitting tobacco funded research proposals to be presented at professional meetings) provided even greater motivation to members to make the message public.

The joint efforts of the council and the Australian Medical Association were a critical factor in the struggle to achieve legislation in Western Australia. High profile deputations from the Australian Medical Association ensured good publicity for both the association and the smoking control message.

Lesson three: educate the decision makers

The dissemination of credible, scientific information in a form that the general public could understand provided a basis for changing attitudes to tobacco. We provided information at every opportunity. Council members appeared before parliamentary committees displaying pathology specimens of human lungs affected by emphysema and cancer as well as *x* ray films indicating vascular disease and other smoking related diseases.

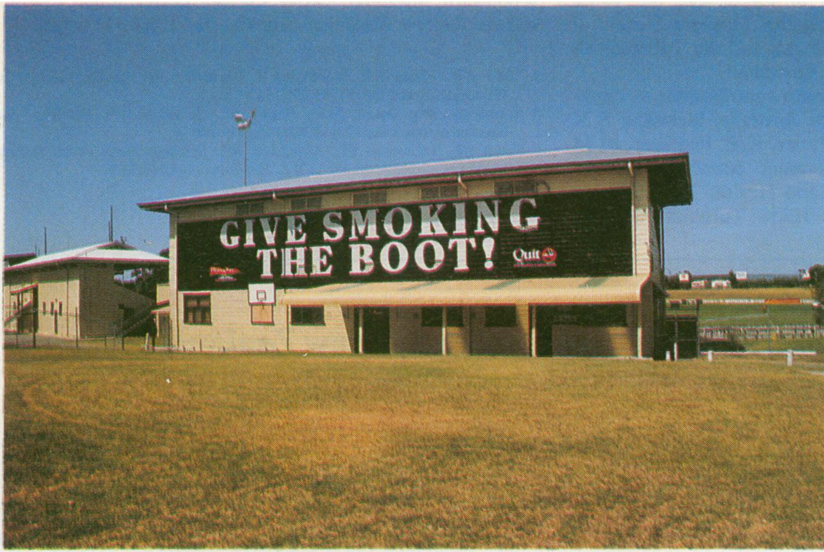
Reworking old research data into new digestible forms is a fundamental task which must be remembered in all health promotion campaigns. Health professionals must not expect science alone to win the war. Scientists often assume—incorrectly—that because the evidence convinces them it will convince others too. The lay public will never tune into more than one or two scientific statements. It is better to give them those fundamental pieces of information over and over, perhaps expressed in different ways, rather than to perplex them with science.

Lesson four: a spoonful of sugar helps the medicine go down

We found that many decision makers were resistant to dry presentations. By "creative epidemiology"—reworking medical data into new and meaningful media stories—the council achieved a high profile, not only within Western Australia, but nationally and even outside the country. The techniques included regular media releases, usually focusing on smoking and children; well planned campaigns; and even shameless gimmicks. The gimmicks included an alternative tobacco company annual general meeting, in which some of the medical royal colleges and other prestigious health groups combined forces to present "the type of AGM which the tobacco industry would hold if it was truthful." These tactics ensured that smoking was in the news week after week. They also ensured that the council was not only given the credibility that accrues to the medical profession but also regarded with good humour. This last, in particular, helped to minimise the effects of the "fanatic" label often given to the council by the tobacco industry.

Lesson five: invade the corporate world

The council also ventured into the world of commerce and bought small parcels of shares in tobacco companies for reselling to some of its members as single shares. The shareholders exercised their shareholder rights at the annual general meetings of tobacco companies by raising questions about deaths caused by smoking during the preceding year. In 1988 the council offered to support the takeover of a tobacco company by Sir Ronald Brierly, a New Zealand businessman, on the condition that it diversify from tobacco investments. It was hardly surprising that 17 shareholders, each with a single share, failed to help secure national control of this multinational organisation, but their attempt did inject some humour into the media coverage which ensued—



Health message replaces a billboard tobacco advertisement at a football ground

and also ensured that the health message was heard yet again.

Lesson six: personalise the issue

We found that personalising the statistics on smoking and health was an extremely valuable tool when lobbying politicians. The "smoking death card" project coordinated by the council for the Western Australia branch of the Australian Medical Association was modelled on the British Medical Association's "black edged" card project: participating doctors sent postcards to their parliamentary representatives which read "A patient of mine who lived in your electorate died of .... It is my opinion that the major cause of this person's death was cigarette smoking."[3] This campaign generated a high level of public interest. More importantly, it reminded politicians that not only did they hold partial responsibility for such deaths but also that political action could help to prevent similar ones.

Lesson seven: develop a strategy and stick to it

The campaign to raise public awareness about the smoking epidemic in Western Australia was conducted in well defined but overlapping stages. The first stage was to influence the general population. The second was then to encourage the general population to influence politicians to follow. The third was to exert direct influence on those politicians, already receptive through the pressure from their electorate, to bring about new legislation. The fourth stage was that the change in legislation would in due course change the attitudes and behaviour of the general population. As these campaigns continued, the breadth and depth of support in the community rose progressively and continues to rise to this day, evidence that the council's strategies were effective. Unless there is a strategy there is an implicit danger that we will win many small conflicts but make no real headway. Indulging in ad hoc activities is futile unless they are part of some wider plan.

Lesson eight: recruit a team of supportive community members

We found that many community groups and individuals in Western Australia were concerned about the health effects of tobacco. We encouraged our affiliated groups such as the Non-Smokers' Movement and other individuals, including academics and doctors, to write letters to newspapers expressing their opinions. Parliamentarians who represented country areas were particularly sensitive to the influence of doctors in their electorates, and letters reflecting personal and local issues indicated widespread community awareness of the smoking issue, which in turn influenced the actions of politicians.

Lesson nine: minimise the opposition and maximise supporters

One of our strategies established during the campaign to ban tobacco promotion was that of minimising potential opposition (and maximising support). In August 1989 the council conducted a public campaign in conjunction with the Australian Medical Association, of which one specific component was SWATS (Sports Without Any Tobacco Sponsorship): a register of prominent and successful sports people opposed to tobacco sponsorship. This campaign acknowledged that mass change of previous loyalty to tobacco companies from sportspeople was unlikely, but aimed to pre-empt any criticism of legislation by seeking support for the general principle of phasing out tobacco sponsorship and replacing the lost revenue. Most importantly, the council emphasised the need to fight the right opponent—the tobacco industry. In all of its campaigning, the council was very clear that it was against smoking—and not against smokers.

Conclusion

In the Bible David was sustained by both moral righteousness and a carefully developed stratagem in his altercation with Goliath. With patience and careful aim he defeated his physically superior opponent. Similarly, in Western Australia the encounter between the relatively small but morally righteous health interests and the corporate colossus of the tobacco industry has resulted in a victory for health after a protracted contest.

The victory was the result of a combination of tactics, including the coordination of professional networks, the education of decision makers, the recruitment of a team of supportive community workers, and the minimisation of opposition. But most importantly, it was a victory brought about by strategic planning and execution.

Last December saw the third anniversary of the Tobacco Control Act. The legislation has ended the distribution of free samples and competitions involving tobacco products, raised the penalties for the sale of tobacco to minors, prohibited tobacco sponsorship, and established the Western Australian Health Promotion Foundation. It will also restrict tobacco advertising to the point of sale only from July 1994, when the last outdoor billboards are removed. The council and other advocates of smoking control will continue to work for an end to all remaining forms of tobacco promotion, for further increases in tobacco taxation as a disincentive to smoking (particularly among children), for smoking prevention programmes in schools, and for smoke free public places.

The foundation members of the Australian Council on Smoking and Health (Western Australia) included representatives from the Royal Australian College of General Practitioners (Western Australian faculty), the Asthma Foundation of Western Australia, the Australian Medical Association (Western Australian branch), the Cancer Foundation of Western Australia, the College of Pathologists of Australia (state committee, Western Australia), the Conference of Seventh Day Adventists (Western Australian region), the Department of Public Health of Western Australia, the Health Education Council of Western Australia, the National Heart Foundation (Western Australian division),

the Royal Australasian College of Physicians, the Royal Australasian College of Surgeons, the Thoracic Society of Australia (Western Australian branch), and the Tuberculosis and Chest Association of Western Australia.

Many people have made important contributions to smoking control legislation in Western Australia, including B K Armstrong, H R Elphick, R M Porter, K W Faulkner, M M Daube, and other past and present councillors of the Australian Council on Smoking and Health; Tom Dadour; Barry Hodge; Judyth Watson; Hilda Turnbull; Stephen Woodward; Suzannah Carter; Glenice Porter; Jude Comfort; and the Western Australian Smoking and Health Program.

1 Musk AW, Shean RE, Woodward S. Legislation for smoking control in Western Australia. *BMJ* 1985;290:1562-5.
2 Armstrong BK, Daube MM, Shean RE. A smoke-free Australia—our bicentenary resolution? *Med J Aus* 1988;149:1-2.
3 Shean RE, Thompson PL, Armstrong BK. Smoking death cards: making smoking a notifiable disease in WA. *Med J Aus* 1988;148:58-9.

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Improving the preregistration experience: the New Zealand approach

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There is currently much debate about how to improve undergraduate medical education, and in particular on how best to prepare students for clinical responsibility. For 20 years a period of trainee internship has formed part of New Zealand medical students' undergraduate training, and the model could have much to offer the United Kingdom. Students take their final examinations at the end of the second clinical year; they spend their final year in a series of eight clinical attachments, during each of which they shadow a preregistration house officer or senior house officer. As trainee interns they are paid 60% of a house officer's salary for their clinical work, which is supervised by the firm's registrars and consultants under the overall responsibility of the head of the academic department. The order of the attachments is determined on educational, not service, grounds, and trainees have to attend educational sessions and pass assessments on each attachment. The trainee internship, funded jointly by the education and health departments, offers a more seamless transition from student to house officer and aims at improving both general medical education and clinical training.

Attachments during the trainee intern year

	Weeks
Medicine	8
Surgery	8
Paediatrics	4
Obstetrics and gynaecology	4
General practice	4
Psychological medicine	6
Medical and surgical reserve	2
Electives	12

The current discussions on medical education in Britain, in particular the undergraduate course, combined with the widespread concerns about the quality of education and experience of preregistration house officers, have lead to debate about the most appropriate arrangement for the continuum of undergraduate education through to full registration.[1-3] Medical educationalists in New Zealand have given much thought to the problem of providing a challenging final year to the undergraduate course while providing a seamless transition from student to doctor. Little has been published on the New Zealand solution to this dilemma, but it merits careful consideration in the present debate in the United Kingdom.

About 20 years ago there was considerable dissatisfaction with the New Zealand medical curriculum: final year students were bored, and their capacity for self directed learning was not being stimulated. There were too many lectures and insufficient concentration on acquiring clinical skills. Recognising that students learn best when learning takes place in the context of their interests, career plans, and abilities,[4] the dean of Otago Medical School, Sir Charles Hercus, had some years previously introduced a three month clinical assistant attachment between the last two years of the course for his students. During this period medical students shadowed a house officer and received a salary. Although the attachment was enjoyed by the students, there were still deficiencies, and the concept of the trainee intern was introduced to the Auckland School of Medicine by Professor Eric Nanson in 1972[5] and to the Otago Schools in 1973. Those who taught in these medical schools both before and after the introduction of the programme thought that it was an advance that made the year a stimulating one which better prepares people for professional responsibilities. Indeed, after the introduction of the trainee intern year many consultants found that preregistration house officers were much more confident than they had previously been. As in the United Kindom, the newly qualified house officer has been required to undertake one year of house jobs but encouraged to complete a second, senior, year before entry to specialist training programmes. The sustained improvement in the quality of first year preregistration house officers is now contributing to a debate over whether a second year at house officer level is still advisable.

The New Zealand Arrangements

The schemes running in the four main teaching hospitals are similar in outline: the following account describes the programme at Christchurch School of Medicine. The undergraduate clinical course is broadly similar to the curriculum in the United Kingdom under the old GMC regulations, but, as in the United Kingdom, changes are now being introduced. At the end of the second clinical year undergraduates take their final formal written examinations, and they then rotate through eight attachments of varying length (see table). In Aberdeen students also complete their final written examinations in the second clinical year, but they then continue to rotate through firms in small groups in their final clinical year.[6] In New Zealand, however, the final year student becomes a trainee intern and on each attachment works closely with one preregistration house officer or senior house officer; both are closely supervised and taught by the firm's registrar and consultant. On occasion, trainee interns may assume the duties of an absent house officer.

APPRENTICE HOUSE OFFICERS

In effect trainee interns are apprentice house officers who have both educational and service components to their work. The service duties of the trainee intern are similar to those of the house officer and are arranged by the head of the academic department concerned. The trainee intern usually manages about one third of the patients managed by the clinical firm. Trainee interns may not sign death certificates, prescriptions that will be dispensed outside the hospital, or prescriptions for narcotics.

A further difference between the trainee intern and the newly qualified doctor is that the rotation of assignments for the trainee interns is under the

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