problem, especially if a child starts off by taking sugar free medicines and is not allowed to develop a taste for a particular sugary medicine. Other doctors mentioned that they did not always have the time to look through the *British National Formulary* or *MIMS* to find a sugar free variety—but, in these days of prescriptions that are issued by computer, quickly scanning the drug dictionary held in the computer's memory to identify a sugar free alternative is possible. Software manufacturers could therefore have a leading role in promoting sugar free medicines by ensuring that these are listed before the ones that contain sugar, or by highlighting the sugar free preparations.

To minimise the harmful effects of those medicines that are available only in the sugar form it is recommended that, whenever possible, they should be taken at mealtimes, not between meals, and definitely not last thing at night or during the night.[4] The flow of saliva is greatly curtailed at night, so the protective cleansing and buffering actions are lost; hence a sugary medicine taken at this time is particularly damaging to teeth.

A relatively new concern has been the recognition of the detrimental effects on dental health of children who are taking liquid nutritional supplements—for example, young patients who are intolerant of lactose or protein. These preparations are listed in the section on borderline substances in the *British National Formulary*. Many of them are listed as being lactose free; in addition, the formulary indicates that they are also sucrose or fructose free. This implies that they are "sugar free," but they usually contain glucose as the source of carbohydrate. Although sucrose is the most cariogenic sugar, glucose runs a close second, and if they are taken regularly between meals or in a bottle as a comforter last thing at night destruction of the teeth is common.

Parents should be advised that these borderline substances are rich in sugar and are as harmful to the teeth as any other drink that contains sugar and should be used as food intakes at set times, not as drinks to be taken at will or as comforters. Young patients taking drugs containing sugar long term should be prescribed a fluoride supplement and advised to register with a dentist for routine screening and advice.

If the tradition of giving children medicines that contain sugar is to be broken it is essential that doctors take the lead by prescribing sugar free medicines whenever possible.

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1 British Medical Association, Royal Pharmaceutical Society of Great Britain. *British National Formulary Number 29 (March 1995)*. London: BMA and RPSGB, 1995:11.
2 Mackie IC. Helping the consumer to make better choices of medicines. In: Rugg-Gunn AJ, ed. *Sugarless—toward the year 2000*. London: Royal Society of Chemistry, 1994:104-11.
3 Bentley EM, Mackie IC, Fuller SS, Brown C. Smile for sugar-free medicines: a dental health education campaign. *Journal of the Institute of Health Education* 1994;32:36-8.
4 Bentley EM, Mackie IC. A qualitative investigation into general medical practitioners' prescribing habits for children prior to a dental health education campaign. *Health Education Research* 1993;8:519-24.
5 Mackie IC, Bentley EM. Sugar-containing or sugar-free paediatric medicines: does it really matter. *Dental Update* 1994;21:192-4.

Doctors who smoke

Should medical students who smoke be channelled away from primary care?

An apocryphal tale in public health, said to have originated from a candid tobacco industry executive, is that each doctor who smokes is worth hundreds of thousands of dollars to the industry. This is certainly an understatement when it comes to the small group of well rewarded doctors and scientists who routinely do the industry's bidding for them in government inquiries and in the media.[1] But what of general practitioners who smoke? There are two considerations here.

The first consideration concerns doctors' roles and, many would add, responsibilities as exemplars. A recent Australian study of smokers from low socioeconomic groups found that half of them agreed with the statement that "a lot of doctors smoke."[2] In fact, only 9% of male and 4% of female doctors in Australia admit to smoking cigarettes—the lowest occupational rate yet reported.[3] Such beliefs may reflect the public's scepticism about virtue but are more likely to be due to the amplification of gossip about the small proportion of doctors who parade their smoking. Whatever the origin of this belief, the community may have finely set antennas for hypocrisy: how can doctors condemn smoking when so many of them do it themselves, and, by extension, "Why should I stop smoking when plenty of doctors don't?"

The second consideration is whether smoking by doctors inhibits any of them from counselling patients about smoking. Despite the enormous publicity given to the health consequences of smoking and, more recently, the efforts of drug companies to promote nicotine replacement therapy,[4] the depressing fact remains that doctors are either blind to their patients' smoking or unwilling to raise the issue. A recent British study reported that less than one third of smokers could recall being given advice to stop by their general practitioner.[5] In Australia just over half of smokers had been given such advice[6] and general practitioners could identify only 62% of their patients who smoked.[7]

An international study by Crofton and colleagues of smoking among medical students in 42 countries, which asked the students about their knowledge of its health consequences and looked at the implications for medical education, has reported disturbing levels of smoking and widespread ignorance about diseases caused by smoking.[8-12] In Europe nearly one in five male medical students smoke. In Japan the rate is one in three, with only just over half of students agreeing that cigarette smoking causes lung cancer. Smokers generally tell the truth about their smoking, but asking medical students if they smoke may be like asking theology students if they blaspheme.[13] Many of the self reported rates of smoking among medical students are likely to be underestimates. Crofton's group has circulated its findings to the deans of all European medical schools and asked them to take action. Some will be spurred into reviewing their curriculums.

But should medical schools do more? Is there a case for selecting only non-smoking medical students on to training schemes for primary care? Such a policy might invite analogies about the suitability of obese and sexually reckless students and raises the question "Where will it end?" Yet other professions, recognising the importance of public confidence, adopt policies about their members' lives that the community

accepts: whatever their talents, people who have been declared bankrupt cannot sit on company boards and those with criminal records cannot practise law. Is it time to debate whether a medical student who smokes should be channelled away from primary health care?

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1 Warner KE. Tobacco industry scientific advisors: serving society or selling cigarettes? *Am J Public Health* 1991;81:839-42.
2 Chapman S, Wong WL, Smith W. Self-exempting beliefs about smoking and health: smoker and ex-smoker differences in a low socio-economic sample. *Am J Public Health* 1993;83:215-9.
3 Smith G. Smoking GPs stubbed out. *Australian Doctor Weekly* 1992 Oct 18.
4 Silagy C, Mant D, Fowler G, Lodge M. Meta-analysis on efficacy of nicotine replacement therapies in smoking cessation. *Lancet* 1994;343:139-42.
5 Silagy C, Muir J, Coulter A, Thorogood M, Yudkin P, Roe L. Lifestyle advice in general practice: rates recalled by patients. *BMJ* 1992;305:871-4.
6 Mullins R, Borland R. Doctors' advice to their patients about smoking. *Aust Fam Physician* 1993;22:1146-55.
7 Heywood A, Ring I, Sanson-Fisher R, Mudge P. Screening for cardiovascular disease and risk reduction counselling behaviors of general practitioners. *Prev Med* 1994;23:292-301.
8 Tessier JF, Freour PP, Crofton JW, Kombou L. Smoking behaviour and attitudes of medical students towards smoking in fourteen European countries. *Eur J Epidemiol* 1989;5:311-21.
9 Tessier JF, Freour P, Belougne D, Crofton J. Smoking habits and attitudes of medical students towards smoking and anti-smoking campaigns in nine Asian countries. *Int J Epidemiol* 1992;21:298-304.
10 Tessier JF, Freour PP, Nejjari C, Belougne D, Crofton JW. Smoking behaviour and attitudes of medical students towards smoking and anti-smoking campaigns: a survey in 10 African and Middle Eastern countries. *Tobacco Control* 1992;1:95-101.
11 Tessier JF, Freour PP, Nejjari C, Belougne D, Crofton JW. Smoking behaviour and attitudes towards smoking of medical students in Australia, Japan, USA, Russia and Estonia. *Tobacco Control* 1993;2:24-9.
12 Crofton JW, Freour PP, Tessier JF. Medical education on tobacco: implications of a worldwide survey. *Med Educ* 1994;28:187-96.
13 Patrick DL, Cheadle A, Thompson DC, Diehr P, Koepsell T, Kinne S. The validity of self-reported smoking—a review and meta-analysis. *Am J Public Health* 1994;84:1086-93.

Obituaries: the future

Developing by evolution not revolution

Obituaries are one of the most popular sections of the *BMJ*. The many letters that we received in response to our last editorial on obituaries and the high response rate to our questionnaire on the subject confirmed their popularity.[1 2] The letters and the answers to the questionnaire have helped us consider how to respond to the central problem: how to publish rapidly in a limited number of pages an ever increasing number of obituaries, preserving their accuracy and usefulness and increasing their readability. We think that we can achieve this through evolution rather than revolution.

Many diverse opinions were expressed by our 110 correspondents and 646 respondents to our survey sent to 1070 doctors, but some things emerged very clearly: most readers want obituaries kept, almost all were keen that we keep space for "ordinary" doctors, and a third wanted more attention paid to the subjects' failings. Consistently respondents thought that shorter obituaries would be better, and they strongly preferred a single paragraph: many would also accept, however, that the section should be flexible, with a mixture of death notices, short paragraphs, and longer accounts.

The major difference between the obituaries and other sections of the journal is that virtually every contribution is published. What's more, editing is mostly restricted simply to shortening. Elsewhere in the journal peer review eliminates all but 15% of submitted manuscripts, which are then edited to make them as clear and interesting as possible. To institute such a drastic "gatekeeper" approach to the obituaries would be cruel and unfair. Yet we learn a lot from the best newspapers, particularly the *Independent*, which has greatly developed the status of the obituary section. It pioneered such welcome features as vivid and frank assessments of people's failings as well as their achievements, and in their revitalised form obituaries have become still more popular features in newspapers. Even the international publication the *Economist* has introduced them.[3]

Above all, as elsewhere in any publication, the readers' interests are paramount. Everybody sympathises with the bereaved, but the proper forum for condolences is the private letter. Obituaries are not the place for expressions of sympathy or the honeyed cliches that currently give the sameness to so many accounts. Often major achievements can be covered in one or two sentences: it is the events behind these that may justify a longer account. And "top" or "famous" doctors should not necessarily get a longer obituary than "ordinary" doctors, whose lives may make much more interesting reading when well written. Every case has to be judged on its merits.

Starting in the autumn, we propose applying to the obituary section some of the approaches used elsewhere in the journal. Each submission for the obituary section will be assessed by a small editorial committee (chaired by Stephen Lock, formerly editor of the *BMJ*, and including outside practising doctors), who will recommend not whether it should be published but the format in which it will appear. (We will very soon be advertising for doctors to join the committee, but anybody interested could write to us now.) We will publish obituary notices (of about 50 words) of everybody, and we will hope to publish these within weeks of the death. Currently, obituaries are published for only about a third of British doctors and many months after their deaths. The delay is caused partly by people taking a long time to submit obituaries and partly by the large numbers of longer obituaries. We hope now that people will send us obituary notices within days of death. In addition, we will try to identify—through death notices in the newspapers, BMA records, and other means—deaths of doctors; we will then gently prompt relatives to send us an obituary notice. In this way we should be able to mark the death of many more doctors than at the moment and more quickly. Our aim is to clear our current backlog by the end of the autumn.

Obituary notices should include full name, date of birth, cause of death (if possible), and a short summary—in one or two sentences—of major achievements inside and outside medicine. Many families will feel that publication of such an obituary notice will suffice, but we will also be pleased to receive longer obituaries for consideration. Publication of an obituary notice will not preclude publication of a longer obituary, but we hope ideally to receive the longer obituary at almost the same time as the obituary notice: we can then publish longer obituaries within weeks of death. Sometimes an obituary notice will not be necessary if we receive the longer obituary within days of the death.