SMOKE SCREEN AROUND ORAL SNUFF

SIR,—In a 1986 editorial[1] you noted that a "curious sense of déjà vu prevails" over the parliamentary debate on the restriction of access to oral snuff, a smokeless tobacco product that has been introduced into the UK by the United States Tobacco Company. Many of the actions under consideration have previously proven to be ineffective in preventing young people from taking up smoking, and you wisely called for stronger measures.

In the 1960s, cigarette manufacturers relied on statements of the American Medical Association (AMA) to challenge the findings of the Surgeon General of the Public Health Service that cigarette smoking is the leading cause of lung cancer.[2] Recent events in the USA and the UK indicate that tobacco manufacturers may be repeating this history as they attempt to create an illusion of scientific controversy about the health effects of smokeless tobacco products. In December, 1985, the AMA issued a report[3] which failed to draw any conclusions about the carcinogenic effects of smokeless tobacco and called for more research. Six months later, the Surgeon General published a report[4] which concluded that smokeless tobacco use is causally related to oral cancer, gum disease, and nicotine dependence. The difference between these conclusions is probably explained by the limited number and type of studies considered by the AMA. The AMA cited 9 studies in man on smokeless tobacco use and oral cancer, including only 3 North American case-control or cohort studies. No work in animals was reviewed. The Surgeon General reviewed 17 case-control and cohort studies done in Western Europe and North America, as well as 48 animal studies.

In May, 1986, a British Member of Parliament, Laurence Pavitt, wrote to the United States Tobacco Company to solicit comments on the Surgeon General's report. The reply cited the AMA report as evidence that the use of smokeless tobacco has not been shown to be causally related to oral cancer, quoting that "disagreement remains about the health effects of chewing tobacco and using snuff". This quote was taken from a sentence that relied on a reference to Grasso et al, which provided other statements including: "the specific known causes of cancer are few" and "also remaining to be explained is why some persons who never use tobacco develop cancer of the oral cavity". Such statements are similar to those that cigarette manufacturers have used before to challenge the association between smoking and cancer.

The AMA report provided the following source for this reference: "Grasso P, Kupper LL, Jennings BR, La Via MF, Weathers DR, Furst A: Written statements submitted to the Massachusetts Department of Public Health Hearings, Boston, Feb 22, 1985." This citation is incomplete. These statements were submitted in a document entitled: "Memorandum of Smokeless Tobacco Council, Inc in opposition to proposed regulations to declare snuff to be a hazardous substance and to require a warning label. Boston, Massachusetts Department of Public Health. Feb 7 and 22, 1985." The Smokeless Tobacco Council Inc is an industry trade-association financed largely by the United States Tobacco Company. Efforts to correct this incomplete citation have been to no avail.

It would appear that the scientific debate about smokeless tobacco is going "back to the future".

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2. Rosenberg J. The AMA tackles smoking. *NY State Med J* 1985; 85: 146–65.
3. Council on Scientific Affairs. Health effects of smokeless tobacco. *JAMA* 1985; 254: 1038–41.
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BOYCOTTS AND MEDICINE

SIR,—In their letter supporting an academic boycott of South Africa (May 30, p 1265) Dr Hall and others say that most South African doctors accept the status quo. Where is the evidence for this? If by status quo they mean the "apartheid-riven health system" then they are being unfair to those non-white and white doctors who so vehemently oppose the South African Government policies.

The allegation of an unbalanced distribution of health care is true of this country as of any other developing nation. In a vast country like South Africa it is just not possible at present to ensure that rural communities have access to medical care of the quality available in the bigger metropolitan areas. Like Britain, South Africa has made great strides in health improvement, but even in the UK one notes that infant mortality is still 67% higher in Pakistani-born communities than amongst native Britons. Our problems are numerically much bigger, and are those of developing Africa and not of Western Europe.

Do your correspondents suggest that by the abandoning of apartheid all health problems will be solved? They need only observe what goes on across some of South Africa's borders. Our most urgent need is to wipe out deficiencies and shortcomings of the South African health system by providing more money for education, basic health care, and better housing, to mention a few priorities only. The money for this will come largely from the much-maligned whites, who pay for the health services of three-quarters of the population unable to do so.

Hall et al are apparently able to better identify the "major Black opposition grouping" (whose call for a boycott they support) six-thousand miles away than we can in South Africa. They make the usual mistake of identifying majority with the most articulate. Nobody knows at present who represents the major Black opposition grouping in South Africa, in view of the ethnic divisions that exist. It is unbelievable that they should advocate abandoning all support for the South African medical profession in preference to that for an unidentified political grouping.

Like most South African doctors I am committed to a fair and equal health service for all and to that end we are making progress, albeit not as fast as we would like. What the South African medical fraternity needs is encouragement and not boycotts, if we are to ensure optimum professional training and academic enrichment of our white and non-white doctors. Very few of South Africa's health critics practise what they preach by working in the rural black African regions, where help is most needed. Instead they snipe from the comfort of ivory towers.

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DOSES FROM CHERNOBYL RADIOCAESIUM

SIR,—Estimates of the radiation dose received by the population of the European Community as a result of the Chernobyl reactor accident have been published recently.[1] These estimates were based on early information about radionuclides measured in the environment and in foodstuffs and on standard assumptions about transfer of activity and intake by persons. A substantial proportion of the doses arises from intake of radiocaesium. The ease with which radioisotopes of caesium can be measured in the human body enables us to determine dose from this source independently and without recourse to assumptions about intake rates and activity concentrations in dietary components. The National Radiological Protection Board is collating all available data on radionuclides measured in UK residents, but this compilation will inevitably take some time. In the interim, we wish to draw to your attention some preliminary data obtained in two regions of England.

Dose estimates for the UK[1] have been calculated separately for a number of regions which have been delineated according to meteorological conditions at the time of passage of the contaminated air mass. For example, Cumbria suffered heavy rainfall and hence higher deposition of radionuclides than the rest of England. As a result, peak concentrations of radionuclides in milk and meat