

CANDY CIGARETTES

To the Editor: Cigarette smoking among children and adolescents is a major source of concern to physicians. However, in spite of much handwringing over this growing problem, the medical profession has concentrated its efforts on smoking-cessation programs, at the expense of programs for prevention. I believe that physicians have overlooked some of the subtle but important aspects of the promotion of cigarettes to children.

Our British colleagues^{1,2} have pointed out that candy cigarettes are sold or given to children by parents and other adults, thus delivering a message of adult approval. In our country, the Philadelphia Bubble Gum Corporation of Havertown, Penn. (better known by its Swell trademark), produces a line of bubble-gum cigarettes with no fewer than eight brand names identical to the real ones — Camel, L&M, Lucky Strike, Marlboro, Pall Mall, Salem, Viceroy, and Winston — all in packages virtually indistinguishable from those of their tobacco-containing namesakes. The Howard B. Stark Company of Pewaukee, Wis., manufactures and distributes sugar and corn-starch candy cigarettes in packages closely resembling the tobacco variety. Some gourmet sweet shops still sell chocolate cigarettes. And K-Mart, undoubtedly in the interest of the economy-minded consumer, offers generic bubble-gum cigarettes.

These products are sold in airports, pharmacies, and supermarkets and are often displayed alongside real cigarettes. Moreover, as I learned from a six-year-old researcher (Winans S. personal communication), they actually "blow smoke" — confectioner's sugar.

In a letter to a 14-year-old student who had inquired about the youthful image presented in certain cigarette advertising, a public-relations director of R. J. Reynolds wrote, "Our company does not approve of young people smoking" (Firestone W. personal communication). That may be true, but a corporation whose brand names are being infringed on and that has apparently made no effort to alter the situation is outdoing itself in the role of Tartuffe.

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2. Hilton DD. Sweet cigarettes. *Br Med J*. 1978; 2:58.

VIEWS OF RESIDENCY DIRECTORS ON PASS/FAIL

To the Editor: An article in the *Journal* by Moss and his associates reported that in one program surgery residents from medical schools that give grades performed better than residents from medical schools that use the "pass/fail" system, and it recommended that residency-training directors keep this difference in mind when selecting house officers.¹ Although the critical response to this article was overwhelming,² there has been no systematic effort to determine how other residency programs regard this issue.

I wish to report the highlights of a mail survey of 940 directors of residency-training programs, randomly selected and stratified according to specialty and geographic region of the United States. The specialties represented included family practice, general surgery, internal medicine, obstetrics/gynecology, pediatrics, and psychiatry. The response rate was 81 per cent, with 760 usable responses and no difference between respondents and nonrespondents in relation to specialty.

Seventy-three per cent of the directors who responded said that they do not give any preference on the basis of grading policy, but 23 per cent said that they prefer students from graded schools. Over 75 per cent of the directors thought that graded and pass/fail students were equal in medical knowledge, initiative and motivation, and personal relations. Yet at a statistically significant level, certain types of programs were more likely to choose graded students when selecting residents and to rate the performance of residents from graded schools higher than that of those from pass/fail schools. Specifically, directors of programs in surgery, medicine, and obstetrics/gynecology and directors, regardless of specialty, who filled all their positions through the National Residency Matching Program were more likely to select graded students for residency training and to rate their performances higher in terms of medical knowledge.

These programs did not perceive differences in performance in the areas of initiative and motivation or relations with patients.

When asked how a school with a pass/fail system could ensure that its students were evaluated properly for postgraduate training positions, 38 per cent of the directors suggested a return to grades; 22 per cent suggested that the dean's letters and faculty letters should not exaggerate a student's strengths, and 17 per cent wanted more information in the form of uncensored quotations from faculty who had contact with the student in clinical settings.

Thus, although my survey found that 75 per cent of directors of residency training do not agree with Moss and his associates, there are indications that directors in the more competitive programs and in some specialties are more likely to choose students from schools with grading systems. Some directors believe that improvement in the information provided by deans and faculty may overcome the disadvantages that pass/fail students face in applying for residency training; others see a return to grades as the only solution.

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SUTTON'S OR DOCK'S LAW?

To the Editor: Sutton's law, absent from even the most recent medical dictionary, is probably the most widely cited law on American medical wards and is known in England and Europe. It is much more practical and is of wider import to medicine than those of Courvoisier, Laplace, or Poiseuille.

It seems inappropriate to honor or perhaps even immortalize a bank robber, however talented, while the distinguished clinician and teacher who introduced the law to medicine remains virtually anonymous in this regard. Sutton's law first appeared in print as a brief footnote in 1961.¹ In essence, it "recommends proceeding immediately to the diagnostic test most likely to provide a diagnosis,"¹ rather than wasting time on a routine and expensive sequence of examinations. It was William Dock who gave this law, complete with eponym, to medicine. When Sutton was released from prison in late 1969, Lawrence K. Altman interviewed Dock and others and fortunately reported the background; much of what follows is taken from Altman's account in the *New York Times*.²

Finally apprehended after a series of bank robberies, Sutton was asked by a reporter, "Why do you always rob banks?" He replied simply, "Why, that's where the money is."

Shortly thereafter, while on rounds as a visiting professor at Yale, Dr. Dock met a young Puerto Rican woman with a liver disorder not yet diagnosed despite a series of tests. Thinking of schistosomiasis because of her background, and with the conversation between Sutton and the reporter fresh in his mind, Dock suggested that the staff follow what he then and there called Sutton's law: go where the money is — i.e., in that particular patient, perform a liver biopsy.

The biopsy was done. Had it been negative, Sutton's law might have died at birth. The initial report, in fact, was negative. But an anonymous and eager student, deeply impressed during rounds by Dr. Dock's acumen (like countless others before and after him), laboriously reexamined the tissue and found the confirmatory ova. Not much later, Petersdorf and Beeson wrote their footnote.

As an anticlimax, Sutton subsequently denied ever having stated the law; but he added "If anybody had asked me, I'd have probably said it. That's what almost anybody would say. Like Dr. Dock said, it couldn't be more obvious."³

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