1991-2 will be put to the committee and dealt with in its next report next year.

I believe that these arrangements are sensible and robust, but if events prove otherwise the committee will report and take appropriate action.

JOHN BLELLOCH

Chairman, Committee for Monitoring Agreements on Tobacco Advertising and Sponsorship, London EC2V 7DN

- 1 Gray S, Bolger G, Ong G. Tobacco advertising on post offices. *BMJ* 1992;305:223-4. (25 July.)
- 2 Committee for Monitoring Agreements on Tobacco Advertising and Sponsorship. *Fifth report*. London: HMSO, 1992.

Suing tobacco industry for damages

EDITOR,—The decision of the US Supreme Court that health warnings on cigarette packets may not always protect the tobacco industry from being sued for damages by smokers who suffer from smoking related diseases has excited interest in Britain.¹ Several firms of solicitors with relevant experience had indicated a willingness to take on such cases, and, in particular, two firms in London, one of them the solicitors for Action on Smoking and Health, have jointly held public meetings for people interested in suing. About 150 potential claimants have come forward, and most of them will apply for legal aid soon.

The cases will present immense legal difficulties and will take at least several years to come to trial, but this is likely to be the only opportunity in this generation to obtain a court ruling on the liability of the tobacco industry. It is important that strong cases go forward that will test all the important variables.

The solicitors are therefore interested in hearing from other possible claimants in five categories: (a) non-smokers whose health has been or is being greatly affected by passive smoking at work, preferably at a single workplace and preferably as recently as possible; (b) smokers who have lived and worked with as little exposure as possible to the smoking of others, or to any environmental hazard, and who have little or no family history of any disease similar to their own; (c) smokers (or ex-smokers) who started smoking as children or young teenagers or who were addicted before 1971, or both, who know what brands they have smoked and preferably have stayed with a single brand or a single manufacturer's brands; (d) smokers whose health has been affected early in life; (e) smokers who suffer from Burger's disease that has been diagnosed recently.

Doctors with patients interested in exploring—at no cost—the possibility of bringing a claim should ask them to write to Action on Smoking and Health, 109 Gloucester Place, London W1H 3PH (tel 071 935 3519), giving a daytime telephone number if possible; the letters will be passed on to the solicitors concerned.

DAVID POLLOCK

Action on Smoking and Health, London W1H 3PH

- 1 McBride G. Cigarette companies may face new lawsuits. *BMJ* 1992;305:9. (4 July.)

Advertising for doctor to work in tobacco industry

EDITOR,—The *BMJ* has for many years highlighted the dangers of smoking and taken a strong editorial line opposing the influence and activities of the tobacco industry. Selena Gray and colleagues' short report adds further to the body of knowledge on the extent of tobacco advertising, and their call for government support for the European Community's proposed directive on a

complete ban on tobacco advertising deserves to be strongly supported.¹

It is thus disappointing to find among the classified advertisements of the same issue of the *BMJ* a large advertisement placed by British American Tobacco to recruit a medical practitioner. In the advertisement the company boasts of being one of Britain's leading manufacturers and exporters of tobacco to some 160 countries around the globe. Although it could not be argued that this form of advertising encourages anyone to take up smoking, it would be preferable if the journal stopped helping this lethal industry to recruit staff.

My view, which I expect is shared by many members of the profession, is that it is unethical for a doctor to work for an industry that spreads so much suffering and death throughout the world. I sincerely hope that the advertisement meets with no response.

GABRIEL SCALLY

Department of Public Health Medicine, Eastern Health and Social Services Board, Belfast BT2 8BS

- 1 Gray S, Bolger G, Ong G. Tobacco advertising on post offices. *BMJ* 1992;305:223-4. (25 July.)

Respiratory medicine: fighting for survival

EDITOR,—Many people will be aware that in the past few years it has been difficult for senior registrars training in respiratory medicine to find consultant posts. This has occurred despite strenuous efforts to create new posts in the specialty, which is acknowledged to be under-represented. In the last review in 1988 the Joint Planning Advisory Committee redistributed some posts to provide a balance around Britain. We have recently become aware that the committee has reviewed the situation prematurely and is now proposing a freeze on all senior registrar appointments for two years. Although we recognise that the constitution of the advisory committee leaves little choice, we believe that this will be a disastrous move for the specialty and all those training in it.

This dramatic move, which the British Thoracic Society has been forced to accept, would immediately stop the flow of trainees into the specialty, and there would be no qualified doctors to fill the posts when they were unfrozen. Furthermore, it would penalise the good training posts which generate promotion because these would become vacant first while bad posts would remain. Superficially, such control might be seen to improve the fortunes of the trainees. This particular edict, however, does not help current senior registrars and curtails the careers of those who have committed themselves to registrar and research posts. Many of these doctors may already have a specialist higher degree and have spent up to five years in the specialty. The representatives of junior hospital doctors on the advisory committee may not appreciate this point.

It is difficult for the advisory committee to obtain current information about new and projected posts. We believe that the consultant growth in respiratory medicine is greater than the committee's information suggests, and at least 12 senior registrars have left the grade in the past year. The NHS reforms are likely to favour expansion of such an important but under-represented specialty, and the imposition of such regulation on training posts when consultant expansion is being deregulated is inappropriate.

We ask the Joint Planning Advisory Committee and the Department of Health to reconsider their proposed action. If there is an excessive number of senior registrar training posts in respiratory medicine the inadequate posts should be removed first. We are all recently appointed consultants with no vested interest other than to see our

specialty survive and develop appropriately. In our view, the proposed solution is the wrong move at the wrong time.

D P DHILLON, JOHN WINTER (King's Cross Hospital, Dundee DD3 8EA); M D L MORGAN, A J WARDLAW (Glenfield General Hospital, Leicester LE3 9QP); D F TREACHER (St Thomas's Hospital, London SE1 7EH); ASHLEY WOODCOCK (Wythenshawe Hospital, Manchester M23 9LT); J C MOORE-GILLON (St Bartholomew's Hospital, London EC1A 7BE); P CORRIS (Freeman Hospital, Newcastle upon Tyne NE7 7DN); J A WEDZICHA, N C BARNES, R M RUDD (London Chest Hospital, London E2 9JX); PHILIP W IND (Hammersmith Hospital, London W12 0HS); JON G AYRES (East Birmingham Hospital, Birmingham B9 5ST); STEPHEN R DURHAM, R M DU BOIS, A B KAY (National Heart and Lung Hospital, London SW3 6NP); D T McLEOD (Sandwell District General Hospital, West Bromwich B71 4HJ); DAVID MITCHELL, PENNY FITZHARRIS (St Mary's Hospital, London W2 1NY); R J D WINTER (Edgware General Hospital, Edgware, Middlesex HA8 0AD); JOHN BRITTON, ALAN KNOX (City Hospital, Nottingham NG5 1PB); J G DOUGLAS (City Hospital, Aberdeen AB9 8AU); M A WOODHEAD (Manchester Royal Infirmary, Manchester M13 9WL); C H C TWORT (St Thomas's Hospital, London SE1 7EH); JOHN HARVEY (Southmead General Hospital, Westbury on Trym, Bristol BS10 5NB); A MILLAR (Royal United Hospital, Bath BA1 3NG)

Diarrhoea, dysentery, and food poisoning

*Last week, owing to an error at the printers after the correspondence pages had been passed by the editorial staff, Dr Anand's letter below was omitted and Dr Hay's reply was printed twice. We have therefore decided to try again.

EDITOR,—Though diarrhoea should be treated with suspicion, A J Hay should not have lumped together the management of bacillary dysentery, amoebic dysentery, and all kinds of food poisoning.¹ As the trophozoites of *Entamoeba histolytica* are not infective (only the cysts are) there is no justification for barrier nursing patients with proved amoebic dysentery. Nor is there any reason for barrier nursing patients with botulism, staphylococcal food poisoning, clostridial food poisoning, or food poisoning due to *Bacillus cereus*.

J K ANAND

Peterborough, PE3 9PJ

- 1 Hay AJ. Diarrhoea. *BMJ* 1992;305:52. (4 July.)

AUTHOR'S REPLY,—J K Anand raises a valid point. My intention, however, was to point out the role of notification and control of infection in the overall management of infectious diarrhoea and not to discuss specific cases. Owing to the similar presentation of many of these diseases, I consider barrier nursing prudent for patients with these diseases on admission to hospital pending a firm microbiological diagnosis. After diagnosis the infection control procedure can be reviewed and revised—hence the need to consult the local infection control policy, as I stated in my letter.

A J HAY

King's College Hospital, London SE5 9RS

EDITOR,—The *BMJ* has long waged a war against multiple or duplicate publication. Do the letters from A J Hay in last week's issue,^{1,2} which I believe may be related, indicate a change of editorial policy? If so, I think we should be told.

JASON PAYNE-JAMES

London E9 7AP

- 1 Hay AJ. Diarrhoea, dysentery, and food poisoning. *BMJ* 1992;305:366. (8 August.)
- 2 Hay AJ. Diarrhoea, dysentery, and food poisoning. *BMJ* 1992;305:366. (8 August.)