high; the standard mortality ratio was 1.42, which is much lower than that in recently published community based studies (one British,² one American³) and similar to that in hospital based series after six years' treatment with levodopa.⁴ Olanow and colleagues also state that the dose of levodopa was fixed in arm 2 and not adjusted to clinical need; if they read our paper's patients and methods section they will see that the dose in both arms of the trial was regulated to obtain optimum improvement.

Mark T Silva and colleagues comment on the causes of death listed in table 3. Inaccuracy of death certificates is well recognised and presents particular problems in elderly people. All entries on the death certificates were coded from the *International Classification of Diseases* (ninth revision), and causes of death were coded according to the World Health Organisation's rule 3 for determining cause of death. For example, if bronchopneumonia was the sole entry in part I of the certificate and Parkinson's disease was mentioned in part II, Parkinson's disease was coded as the cause of death.

As M Gerlach and colleagues indicate, the "on treatment" hazard ratio (1.44) was not significant, but the magnitude of difference was similar to that obtained with the intention to treat analysis. Altogether 60% of the deaths occurred while patients were still in the treatment group to which they had initially been randomised. The interim analyses were carried out annually; a nominal level of significance ($P < 0.005$) was used, which maintained the overall level of significance ($P < 0.05$), assuming a maximum of 10 interim analyses. Between April 1995, when investigators were notified of the findings, and submission of the paper for publication we received additional information on patients, and reanalysis (with these new data included) altered the P value. We would emphasise that all patients' records were flagged at the NHS Central Register. In addition, most of the survivors were seen in 1994, and those lost to follow up were relatively few and equal in the two arms.

As in any other trial, an imbalance between treatment groups in an unrecorded characteristic at baseline may have occurred. The fundamental strength of randomised trials is that both known and unknown confounders are balanced across interventions. Olanow and colleagues and K A Jellinger raise the issue of misdiagnosis. The diagnosis was revised in only 6% of cases in arms 1 and 2, and on the basis of clinicopathological studies probably as many as a fifth of the patients who died would have failed to fulfil confirmatory pathological criteria for Parkinson's disease.⁵ This difficulty, however, reflects the reality of clinical practice. For misdiagnoses to explain our findings the imbalance between the two arms would have to be great. We have calculated that to replicate the number of deaths in arm 2 it would be necessary for 60-89% of patients to have been misdiagnosed, assuming a twofold to threefold relative mortality for these patients compared with those with Parkinson's disease.

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Compliance with infection control procedures in dentistry

EDITOR,—Infection control should be adequately taught and carefully monitored in dental and medical schools.¹ Little objective evidence exists on how compliant dental staff are in undertaking infection control measures. We previously reported that the compliance of British hospital dental staff and students was inadequate: protective gloves were often neither changed nor washed between patients.^{2,3} Only half of staff and students wore protective eyewear, and only about a third wore a face mask. As a result of those observations, infection control procedures were re-emphasised.

Four years later, over a period of five weeks, we observed the compliance of dentists and dental students working in the same primary dental care clinic of the dental hospital. We used a video camera mounted on the ceiling. The camera had been installed two weeks previously, and the staff and students were unaware of its purpose or precisely when it was operating. Procedures were recorded on videotape and later assessed by two clinicians. A total of 215 contacts between patients and the dentists and students were scrutinised, consisting of 114 examinations (79 undertaken by dentists and 35 by dental students) and 101 treatment procedures (71 by dentists and 30 by dental students). The treatments were all surgical or restorative dentistry likely to produce aerosols or splatter. Compliance with hand washing before and after contact with the patient and the use of gloves, face masks, and eye protection were recorded. Other infection control procedures, such as sterilisation of instruments, were not assessed.

We found that the health care workers washed their hands before donning gloves in only 23% of contacts, did not wear gloves in 13%, and changed gloves between patients in only 56% (table 1). They wore face masks during only 82 contacts and protective eyewear in only 62. These observations were similar to those in our previous studies, except that more staff and students were now changing gloves or washing hands between patients.

Thus, even when provided with training and all suitable protective wear, neither hospital dentists nor dental students comply completely with infection control procedures. Indeed, compliance has not greatly improved over the past four years despite additional education of dental staff and students³ and the increasing prevalence of HIV infection and hepatitis C in the general population. The attitudes of dental staff and students to infection control procedures clearly require improvement, but whether additional or modified education measures alone will suffice is unclear. Perhaps legal methods may be the only means

of ensuring adequate compliance with infection control.⁴

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Tobacco advertising

Cigarette advertisements are still allowed on television in Japan

EDITOR,—Bruce Guthrie says that if the British government is serious about reducing smoking it should ban tobacco advertising.¹ I am embarrassed to say that cigarette advertising has not yet been banned from television in Japan. Young people, especially teenage girls, tend to think that smoking is glamorous and fashionable. The increase in the number of young women who smoke is one of Japan's most important problems.² According to the Japan Tobacco Corporation, the prevalence of smoking among women aged 20-29 was 16.6% in 1985 and had risen to 19.5% in 1990.³

According to a survey conducted in 1995, the prevalence of smoking among women in their 20s was 23.3%. The survey also showed that the prevalence of smoking was 58.8% among men and 15.2% among women—in other words, about 27.3 million men and 7.5 million women smoke in Japan. The number of female smokers was the highest since the Japan Tobacco Corporation began its surveys in 1965. Although a total ban on all tobacco advertising may be difficult, the Japanese government should prohibit cigarette advertising on television by law to indicate that it is taking the people's health and future seriously.

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Committee exists to monitor agreements on tobacco advertising

EDITOR,—I read with concern the letter from Bruce Guthrie reporting his survey of poster advertisements for tobacco near schools.¹ Guthrie does not make any mention of the Committee for Monitoring Agreements on Tobacco Advertising

Table 1—Hand washing and use of gloves by dentists and dental students during contact with patients. Figures are numbers (percentages) of contacts

	Examinations		Treatments	
	Dentists (n=79)	Dental students (n=35)	Dentists (n=71)	Dental students (n=30)
Hands washed before gloves put on	11 (14)	9 (26)	9 (13)	21 (70)
Gloves worn	64 (81)	29 (83)	64 (90)	30 (100)
Gloves changed between patients	50 (63)	7 (20)	45 (63)	18 (60)
Gloves neither changed nor washed between patients	5 (5)	0	8 (11)	1 (3)