skin cancer and melanoma in particular.⁴ In view of such evidence the risk-benefit ratio of using ultraviolet A sunbeds should be re-examined, and the medical profession should be more critical of sunbed salons that operate purely for financial gain. The Health Education Board in Scotland and the Department of Health are unequivocal in their advice that sunbeds should not be used for cosmetic tanning.

Disturbingly, a considerable number of sunbeds are still operated by local councils, often in the incongruous setting of a health and fitness suite in a leisure centre. The promotion of machines whose only function is to produce radiation damage to the skin, which may ultimately promote skin cancer, should play no part in the operational policy of modern local councils professing to have the best interest of their constituents at heart. Councils may argue that they are catering for a demand for sunbeds by the public, but this demand is led by ignorance and should be rejected. Caradon District Council removed the sunbeds from one of its leisure centres last February, and Dumfries and Galloway Council removed the sunbeds in five locations from south west Scotland in June. These councils are to be congratulated for putting the health of their constituents ahead of financial gain.

Now that a precedent has been set, all local authorities should seriously consider closing their sunbed facilities. Doctors, and dermatologists in particular, should pressure them to do so.

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People do not apply enough sunscreen for protection

EDITOR,—Despite the conventional wisdom that sunscreens should be recommended to prevent cutaneous malignant melanoma, evidence supporting this is lacking. J M McGregor and A R Young¹ comment on the apparent increased risk of melanoma in people who use sunscreens.² They suggest that people who use sunscreens containing ingredients that mainly absorb ultraviolet B spend longer in the sun because of the reduced risk of sunburn and so increase their dose of ultraviolet A radiation and that this may increase their risk of melanoma. An alternative explanation why use of sunscreens might be linked to the risk of melanoma may simply be that consumers do not apply sunscreens correctly to achieve the expected protection and subsequently overexpose themselves to the sun. The protection offered by a sunscreen is indicated by the sun protection factor, which is assessed after phototesting in vivo at an internationally agreed application thickness of 2 µl/cm². To achieve the rated protection over the whole body a typical adult of surface area 1.73 m² would therefore need to apply 35 ml of the sunscreen—roughly one third of a bottle per application. Not surprisingly, several studies have shown that consumers apply much less sunscreen than this—typically an average of 0.5–1.3 µl/cm².^{3,4} Consequently, the protection received will be considerably less than that expected and in many cases will be closer to half that indicated by the sun protection factor. Fur-

thermore, a study that used the intrinsic fluorescence of sunscreens as a surrogate for application thickness found pronounced variations in thickness (and hence protection) within relatively small anatomical regions, such that many areas to which sunscreen had been hurriedly spread over the skin were protected to a very minor extent, while further areas were left unprotected.⁵

The reported relation between sunscreens and melanoma might be explained more reasonably by the fact that people are underprotected owing to careless application of the sunscreens and then overexpose themselves to the sun. Attention should be given to applying sunscreens liberally and uniformly and allowing them to dry. Products applied too thinly or rubbed vigorously into the skin will not provide adequate protection. Sunscreens should continue to be used in combination with clothing, shade, and appropriate behaviour to prevent excessive exposure to sunlight.

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Knowledge about sunscreens is inadequate

EDITOR,—J M McGregor and A R Young highlight important concerns about the ability of sunscreens to prevent skin cancer.¹ A further problem with sunscreens may be inappropriate application. We conducted a questionnaire survey of 656 parents of schoolchildren in Glasgow in May 1995 to assess their "sun awareness"—that is, their knowledge, attitudes, and behaviour—before a national sun awareness

Table 1—Parents' responses to questions about their knowledge of use of sunscreens

	Yes	No	Don't know
Sunscreens			
Work well for up to five hours	339	185*	112
Work better after swimming	59	501*	76
Work better if used with aftersun lotion	189	313*	134
Work better when you are sweating	12	482*	142
Factor 8 sunscreen			
Is stronger than factor 4 sunscreen	526*	49	61
Is the weakest sunscreen recommended for young children	129	335*	172
Is eight times more protective than no sunscreen	444*	76	116

*Most suitable answer.

educational initiative. Parents of schoolchildren aged 5–11 were approached by three interviewers in a local shop that sold children's clothes and at parent-teacher evenings in eight local comprehensive primary schools. The parents were asked to complete a questionnaire containing 36 multi-

ple choice questions and a single free text question and to give their age, sex, and occupation. Seven questions related specifically to knowledge of use of sunscreens. The participation rate was 97% (636/656). Table 1 shows the parents' responses.

Our findings show that, at least in our local population, there is confusion over the most suitable sunscreen to use in young children, the most appropriate interval for reapplication of sunscreen, and the use of aftersun lotion. This is a further indication that campaigns to prevent skin cancer should concentrate on changing attitudes towards getting a suntan and behaviour.

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Much effort is spent on treating drug misusers in prison

EDITOR,—Chris Ford writes about the allegedly poor treatment that a patient received during his stay in a remand prison.¹ As a former general practitioner, I can both appreciate and sympathise with Ford's feelings when a patient does not receive the treatment that Ford deems necessary. Nevertheless, I find Ford's diatribe against the professionalism and clinical acumen of prison medical staff to be unfounded, inflammatory, and at best an oversimplification of a problem that is all too common and affects the NHS as well as the prison medical service.

Health care standards for the prison medical service have been amended since 1994 to include full detoxification programmes for all substance misuse that is encountered in prisons. These documents are exhaustively researched with full NHS backing and have been thoroughly implemented throughout the prison service. I am interested that Ford asks for a review of these policies: I wonder whether Ford has read them in the first place. For 37% of my admissions, dependence on injected heroin is a substantial problem. A great deal of time, effort, and dedication is spent helping these prisoners with withdrawal and harm reduction; we do not just prescribe methadone, courting overdose or inadequate treatment, as Ford implies. Tabloid reportage about less than optimal health care of prisoners should be viewed with as much scepticism as would befit similar reportage of incompetence in general practice.

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Community leg ulcer clinics

Data were missing from paper

EDITOR,—Deborah A Simon and colleagues report encouraging data from their study of healing of leg ulcers treated in community clinics.¹ Several omissions, however, make interpretation of their findings difficult. The initial size of a leg ulcer has considerable influence on the time to healing. The authors should have indicated the size of the leg ulcers in each group at the onset of each study period and whether significant differences were present. The authors state that if healing did not progress the patient was immedi-