Support from retailers for tightening the Western Australian Tobacco Control Act 1990

EDITOR,—In 1996, 29% of 12–17 year old smokers in Western Australia were able to purchase cigarettes from a retail outlet despite the Western Australia Tobacco Control Act (1990) prohibiting the sale and supply of tobacco products to persons under the age of 18 years.¹ The fines imposed on retailers prosecuted under the Act ($5000 and $200 per-transaction for an individual retailer and a corporate body, respectively) have not deterred retailers from selling cigarettes to minors, suggesting additional measures are needed to reduce adolescent access to cigarettes. We conducted a postal survey to determine the level of support among owners and managers of retail outlets in Western Australia for making it illegal for minors (under 18 years of age) to sell cigarettes and other tobacco products, removing all indoor point-of-sale advertising and having to store cigarettes and other tobacco products out of sight, under the counter.

We chose a random sample of 630 from the 4120 eligible retail outlets in Western Australia listed in the current online Australian Yellow Pages directory. We telephoned each outlet to verify that it was still in business, obtain the name of the owner and manager of the outlet, and confirm willingness to receive the survey.

Consenting owners or managers were asked to complete a 25 item questionnaire rating their level of support using five point Likert scales (“strongly agree” to “strongly disagree”). In view of anecdotal reports of tobacco companies underwriting the cost of refunding shops in return for guaranteed access to a significant proportion of the display area, we asked whether each outlet had received an offer of this kind. We also sought respondents’ age, sex, country of birth, and smoking status.

Of 446 (70%) outlets agreeing to participate, 236 (53%) returned a questionnaire, yielding a 37% response from our original sample. The majority of respondents (71%) felt that cigarettes and other tobacco products were important in attracting passing trade, and 88% reported that, at least half of the time, someone buying cigarettes in the shop would also buy something else. Twenty percent (20%) of respondents were in favour of removing point-of-sale advertising and an additional 19% were undecided. There was little support for storing cigarettes and other tobacco products under the counter (13%).

The considerable support among owners and managers for removing all indoor (point-of-sale) advertising and making it illegal for minors to sell cigarettes is particularly noteworthy. As retailers perceive that tobacco products are important in attracting passing trade, it seems they place a premium on being able to sell cigarettes over and above being permitted to advertise them. Rather, the tobacco companies must feel it is necessary to advertise at the point-of-sale, thus exposing the whole community, young as well as old, non-smokers as well as smokers, to a message that cigarettes are a normal part of life. We have confirmed that tobacco companies do make offers for the cost of refitting shops, with anecdotal reports that they seek, in return, preferential rights to display their products. The reasons behind the low level of support for storing cigarettes and other tobacco products under the counter were not explored, but might include the high cost for remodelling the counter area of shops to accommodate additional storage space for tobacco products.

While further studies should be conducted to verify our results, there is already a foundation on which to build support among retailers for strengthening tobacco control legislation in Western Australia.

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This project was suggested by the advocacy committee of the Smarter Than Smoking project which is funded by Healthway, the Health Promotion Foundation of Western Australia.

¹ Public Health Division, Health Department of Western Australia, the Centre for Behavioural Research in Cancer, Anti-Cancer Council of Victoria.
³ Source: Western Australian Tobacco Control Act 1990, which consists in the extraction of the nicotine from the tobacco leaf. Since the nicotine content of the synthetic nicotine is nil, the state of the smoker is as if he was smoking a non-nicotine cigarette.

Origins of "denicotinised" tobacco

EDITOR,—It has been reported that more than 150 years that nicotine is the chemical in tobacco that is responsible for the perceived salutary as well as the adverse effects among users. Efforts to market “denicotinised” tobacco have repeatedly failed. The 1964 report of the advisory committee to the US Surgeon General stated, “Denicotinized tobacco has not found general public acceptance as a substitute for tobacco’s.”³

How US airlines became smoke free

EDITOR,—The development of the US Federal Aviation Administration policy to prohibit smoking in both the passenger cabin and flight deck of scheduled passenger flights¹ offers lessons that may be considered in other countries and workplace settings. This policy was driven by the findings that environmental tobacco smoke (ETS) is a serious threat to those exposed, that air craft air quality was adversely affected by cigarette smoke, and by frequent complaints of respiratory irritation by crew and passengers.² Similar concerns have been raised in other occupational settings such as
The development and implementation of the policy, however, was slowed and complicated by fears that prohibiting smoking might adversely affect pilot performance. This summary of the policy development and the cited references may be useful to others in developing smoke-free workplace settings in which there are similar challenges of impaired performance and attendant safety concerns.

In 1978, a National Institutes of Health report on cigarette smoking and airline pilots concluded that while smoking itself did not have significant effects on flight safety, the adverse effects of smoke inhalation might adversely affect pilot performance. This finding supported the exemption of the flight deck from the commercial aircraft smoking ban that was passed by the US Congress in 1989. Nonetheless, many airlines voluntarily developed their own policies restricting smoking on the flight decks, and the successful implementation of these policies supported the April 2000 government action to ban smoking throughout commercial aircraft. To conform to the new legislation, the office of the Secretary of the US Department of Transportation and the FAA amended their smoking policies and have published updated rulings. The science documenting the effects of smoking and nicotine withdrawal, as well as treatment options, expanded considerably after 1978, and in 1994 the FAA requested that the Centers for Disease Control assemble an expert panel to follow up on the 1978 report, re-examining the effects of smoking and smoke deprivation relevant to pilot performance. The science documented adversely affect pilot performance the banning of smoking that was ordered by regulators in 2000. In brief, the panel concluded that nicotine withdrawal in dependent cigarette smokers does not generally lead to cognitive and behavioural deficits until at least four hours after the last cigarette. Because more than 94% of US commercial flights are less than four hours in duration it was assumed that there would be sufficient opportunity for pilots not able to completely cease smoking to smoke before flights. Furthermore, the panel observed that nicotine withdrawal related performance deficits could be precipitated by nicotine replacement medications. This knowledge and such medications were not available in 1978. The facts that less than 15% of pilots smoke and that most pilots actually reported discomfort and decreased performance as a result of ETS provided additional support for the policy. The ideal course recommended for tobacco using pilots of longer flights was treatment for tobacco dependence to alleviate withdrawal symptoms and sustain abstinence.

Our discussions with several airlines and government regulatory agencies suggest that the policies are not yet well understood nor have they been adequately disseminated. Nonetheless, it appears that smoking restrictions on flight decks and passenger cabins are being implemented without major problems or concerns regarding safety. In practice, enforcement of such policies may be increasingly manageable as the prevalence of cigarette smoking continues to decline in many sectors of the workforce. Finally, the greater range and accessibility to effective treatments for tobacco dependence and withdrawal available both with and without prescriptions should make this goal more practical.

A critique of nicotine addiction


Although there have been comprehensive reviews of the evidence for the existence of nicotine dependence (for example, the 1998 Surgeon General’s report and the 2000 Royal College of Physician’s report), and there have been brief articles citing evidence contrary to the existence of nicotine dependence (for example Robinson, Psychopharmacology 1992;108:39-59). I am aware of no prior comprehensive review of evidence contrary to nicotine dependence as done in this book. The book is the work of two PhD scientists at Tel-Aviv University. It lists no acknowledgment of funding and does not specifically state whether tobacco industry funding was or was not involved.

The book does not waste time on peripheral matters but focuses on the central tenets of nicotine dependence—that is, nicotine reinforcement, withdrawal, compulsion, and regulation. Much of the book is a methodological critique of the studies cited as evidence of nicotine dependence. For example, the book states animal self-administration studies are inadequate because they did not show facilitation of initiation of self-administration, excluded negative results, and failed to control for non-specific effects in lowering pressures of inadvertent effects of nicotine. It also criticises human self-administration studies for inadequate blinding, excluding negative results and small sample sizes. The book also maintains that nicotine dependence has been shown to be aversive and thus cannot be a motivator.

The major asset of the book is that it describes in detail the most common criticisms of nicotine dependence and their rationale. The major liability is that the book seems to me overly critical—for example, a study is often entirely dismissed if it has any flaw to it. Thus, by this method, a position can only be advocated when the perfect study is done. Unfortunately, the book becomes polemical enough to interfere with one’s reading pleasure. Nevertheless, I would recommend reading this book as I think it important to force ourselves to listen to criticisms and think hard whether there is any truth to them.

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Editor’s note: On receiving this review from Dr Hughes, I asked him to enquire from the authors of the book whether its production had been sponsored by the tobacco industry. They replied: “Several years ago we were approached by a law firm and consequently were paid for our time reading and evaluating some of the literature summarised in the book. Although the law firm refused to reveal its client’s identity, it seems clear that the client is from the tobacco industry. It is important to stress, however, that this law firm was strictly opposed to our publishing the book, and in fact warned that its publication might end our engagement as experts. We surmise that this reaction was for two reasons. First, the material in the book would pre-expose antagonists in law suits to arguments the law firm might use. Second, our critique might compel researchers to do a better job in attempting to establish the role of nicotine in smoking. We decided to publish our book for similar reasons. We believe that our engagement as experts has had no bearing on the conclusions we reach in our book.” (reply truncated)—Hanan Frenk and Reuven Dar.

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