

smoking is considerable<sup>2</sup>; those who take up smoking are not doing so purely out of ignorance. Recent health promotion has therefore concentrated on developing children's self confidence and "refusing skills" so that they are empowered beyond "just saying no." Aidan Macfarlane,<sup>3</sup> however, reflects much sociological work<sup>4</sup> when he mentions the complex motivations that lead to young people's behaviour. The "behind the bikesheds" appeal that risk behaviours have for young people may be beyond the understanding of those who think that the residue of young smokers will be lured by the squeaky clean, sporty, sweet breathed image of abstinence.

Perhaps it is time to rethink the objectives of this aspect of health promotion. If dissuading people from ever starting to smoke is the primary aim then limitation of long term cigarette smoking presumably comes second. Cigarettes are certainly addictive, yet some 11 million people in Britain have managed to give up. The continued advertising and promotion of tobacco should be strenuously resisted, yet the government has not so far seemed inclined to upset the tobacco lobby. There may, however, be a role for health promotion even while governments are still concerned about the patronage of multinational companies. A deliberate shift of focus for health promotion could encourage people in their 20s to give up smoking. Given that by then the teenage assumptions of invulnerability have tended to evaporate, what better time to put away childish things and give up that nasty teenage habit? Undoubtedly far more smokers could give up if only health services were more alert.

Knowledge about the harmful consequences of smoking could be maintained in a low key manner through the school curriculum. A reduction in the barrage of antimoking advice during the teenage years would thus be combined with an increase in health promotion aimed at a more responsive group. This could even have the elusive and much desired effect of reducing the appeal of smoking as a "grown up" activity through reconstructing it as an essentially teenage pursuit.

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- 1 Nutbeam D, Macaskill P, Smith C, Simpson JM, Catford J. Evaluation of two school smoking education programmes under normal classroom conditions. *BMJ* 1993;306:102-7. (9 January.)
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EDITOR,—Don Nutbeam and colleagues evaluate two types of health education initiatives in schools.<sup>1</sup> We agree with Aidan Macfarlane that measures to combat smoking cannot rely exclusively on school education programmes, as this is a multifaceted problem amenable to other effective solutions.<sup>2</sup> It is right to distrust initiatives that depend only on the health and education sectors; in the current political climate this is indeed oversimplistic.

But it should not be taken for granted that these types of programmes are the ideal and only way to approach health education, whether in schools or by health professionals. Both interventions involved minimal, project oriented teacher training and were circumscribed, involving three to five hours' delivery time overall. The movement in health education now is to integrate such teaching into the curriculum as part of a wider process that educates the pupil fully, promoting personal skills development. Even common sense will tell you that children under a variety of other social stresses are scantily equipped for life by a five hour

programme. The paper might have usefully addressed, for instance, the relation of social skills to socioeconomic status of the pupils and the different effects on recipients of the programmes. Nutbeam himself has previously shown that students with a negative attitude to school are more likely to become smokers.<sup>3</sup>

Health promotion has, rightly, moved away from the traditional approach, but let us not dismiss health education fully until it has been properly implemented, let alone evaluated.

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- 1 Nutbeam D, Macaskill P, Smith C, Simpson JM, Catford J. Evaluation of two school smoking education programmes under normal classroom conditions. *BMJ* 1993;306:102-7. (9 January.)
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## Health promotion in general practice

EDITOR,—I write to support Duncan M Williams in his criticism of the ineffectiveness of our GMC negotiators.<sup>1</sup> In my practice we increased our practice nurse staffing by 50% and provided a range of responsible and relevant health promotion clinics, in the spirit of the 1990 charter, but now face the prospect of a substantial reduction in income or to make the nurses redundant. Which other trade union would boast that only 35% of its membership will suffer?

To add insult to injury, our family health services authority is returning our claims for *Haemophilus influenzae* type b immunisation unpaid. We have doubled our medical input to our immunisation clinics and struggled through the difficulties of vaccine availability only to be informed that we are working for no reward. We may receive some payment in September 1994 if we achieve targets. Why have our negotiators not insisted on item of service payment until the date of introduction of target payments, as occurred with the other childhood immunisations?

In order to reduce our losses perhaps we should not renew our BMA subscriptions?

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- 1 Williams DM. Health promotion in general practice. *BMJ* 1993;306:148. (9 January.)

## Lumbar puncture in acute bacterial meningitis

EDITOR,—Minerva's statement that "Most children with suspected acute bacterial meningitis have no contraindications to lumbar puncture, which should be done promptly before treatment is started with intravenous antibiotics,"<sup>1,2</sup> may undermine the advice given by the chief medical officer in 1988 in relation to meningococcal infection.<sup>3</sup> This stated: "The classical features of meningococcal meningitis and of septicaemia may not always be present, particularly in very young children. If the diagnosis is suspected, especially in the presence of haemorrhagic rash, it is important to consider giving parenteral benzylpenicillin before transfer to hospital."

It is unwise for general practitioners and the staff

of casualty departments to delay giving antibiotic treatment until a lumbar puncture has been performed, such a response may prove fatal.<sup>4,5</sup>

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- 1 Minerva. *BMJ* 1993;306:154. (9 January.)
- 2 Mellor DH. The place of computed tomography and lumbar puncture in suspected bacterial meningitis. *Arch Dis Child* 1992;67:1417-9.
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## Organ donation

EDITOR,—We support several of the points in R M R Taylor's editorial on organ donations.<sup>1</sup> Firstly, whatever system is adopted to improve retrieval rates, it must have the approval of the intensive care staff and transplant coordinators since they are most closely concerned. Secondly, there is no reason to believe that any computerised system for storing data on "opting in" would be effective or practical. We view so called elective ventilation of patients who might become potential organ donors with some trepidation. Evidence in its favour is limited to one small British study.<sup>2</sup> As well as raising ethical and moral issues, such a policy might reduce further the provision of beds in intensive care units for patients with illness from which they may recover. Britain already has one of western Europe's lowest ratios of intensive care unit beds to hospital beds.

We agree that the rate of refusal by relatives and the incidence of failure to ask for organs should be minimised. There will always, however, be a few cases in which the clinician thinks that it is inappropriate to ask for organs. This must be accepted. In 1989 Bodenham *et al* reported that refusal of consent by the coroner was a greater problem than refusal of consent by relatives (28% v 17% of failures to retrieve organs).<sup>3</sup> At that time the refusal rate by the coroners in our region was effectively zero. Today a change in policy has produced a refusal rate by the coroner of more than 10% and has resulted in clinicians not considering organ donation in certain types of case (from which criminal proceedings might arise). Many suitable organs are being lost to avoid the possibility of difficulties at trial—that is, when and why did a patient die; who or what was the cause? Whether this is necessary or desirable should be discussed at the highest level by the legal and medical professions. This discussion will be even more urgent if it becomes common for criminal proceedings to arise from road traffic accidents.

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- 1 Taylor RMR. Opting in or out of organ donation. *BMJ* 1992;305:1380. (5 December.)
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EDITOR,—G R Park and colleagues express grave reservations<sup>1</sup> about the Exeter protocol for elective ventilation of potential organ donors.<sup>2</sup> Without