that the total dosage of antimalarial drugs is related to toxicity,[1] it may well be correct, as suggested in Mackenzie's paper, that the true relation is with the daily dose, based on lean body mass. There is an important inference to be drawn from Mackenzie's work—that the normally recommended dosages may well be too high in either very slim people or very fat people.

MICHAEL L SNAITH
Senior lecturer

Institute for Bone and Joint Medicine,
University of Sheffield Medical School,
Sheffield S10 2RX

1 Percival SPB, Meanoch I. Chloroquine: ophthalmological safety and clinical assessment in rheumatoid arthritis. *BMJ* 1968;iii: 579-84.

Smoking among secondary schoolchildren

EDITOR,—The prevalence of regular smoking among 11-15 year olds is alarmingly high and has not decreased much since 1982, when national surveys began.[1] The Health of the Nation target for England—to reduce regular smoking in this age group from 8% in 1988 to 6% in 1994—has not been met. In 1992, 10% in this age group smoked regularly.[2] But has the wrong target been set?

In 1989, experts in the United States who analysed the outcomes of evaluations of a variety of school based approaches to controlling smoking concluded that the best that could be hoped for was a delay in taking up smoking.[3] Regular smoking was unlikely to be greatly affected. In England cross sectional surveys of the prevalence of smoking nationally have shown that the percentage of boys aged 11-15 who have never tried a cigarette increased significantly from 45% in 1982 to 57% in 1992 ($P<0.001$).[2] The proportion of girls who had never smoked increased from 49% in 1982 to 57% in 1992 ($P<0.001$). Scottish statistics show increases from 37% to 52% in boys and 41% to 45% in girls over the same period.[2]

The increase in people in England who have never smoked has occurred in all age groups; even at the age of 15 the percentage of boys who had not tried a single cigarette increased from 29% in 1982 to 39% in 1992 ($P<0.005$). For girls the increase in this age group from 27% to 33% was not significant ($P<0.05$).[2] Research has shown that trying one cigarette in adolescence is one of the strongest predictors of going on to become a smoker,[4] so the longer this initiation can be delayed the better. Few people start to smoke after the age of 18. The earlier smoking is started the greater the health risks. If smoking starts at the age of 15 life expectancy is reduced by eight years. If it starts at the age of 25 life expectancy is reduced by four years.[5]

If so much can be achieved by education alone how much more could be done if teachers' school based efforts were supported by government action on the influences outside school on children's smoking: it should ban tobacco advertising, develop generic packaging, and increase taxes for cigarettes.

ANNE CHARLTON
Director
DAVID WHITE
Statistician

CRC Education and Child Studies Research Group,
School of Epidemiology and Health Sciences,
University of Manchester,
Manchester M13 9PT

1 Secretary of State for Health. *The health of the nation.* London: HMSO, 1992.
2 Thomas M, Holroyd S, Goddard E. *Smoking among secondary school children in 1992.* London: HMSO, 1993.
3 Glynn TJ. Essential elements of school-based smoking prevention programmes. *Journal of School Health* 1989;59:181-8.
4 McNeill AD, Jarvis MJ, Stapleton JA, Russell MAH, Eiser JR, Gammage P, *et al.* Prospective study of factors predicting uptake of smoking in adolescents. *J Epidemiol Community Health* 1988;43:72-8.
5 World Health Organisation. The health of youth: facts for action. In: *Youth and tobacco.* Geneva: WHO, 1989. (Document No A42/technical discussions/3.)

Vaccinations for travellers

EDITOR,—There is widespread concern that many travellers to tropical countries are not adequately protected against malaria. Either a public health message about the hazards of such travel has never reached them, or they have chosen to disregard it. Vivien Hollyoak is concerned that new regulations preventing the prescription of prophylactic antimalarial drugs on the NHS will worsen this situation.[1] I hope that general practitioners will not use the change to milk an unjustified additional private prescription fee (average cost £6) from all travellers as Hollyoak assumes. Nevertheless, for travellers using mefloquine, and particularly for longer trips, prophylaxis now costs much more.

The new regulations are evidently driven by the need to contain drug budgets, but the decision to charge for prophylactic drugs while general practitioners continue to be reimbursed for the cost of travel vaccines is curious. Almost all travellers to exotic places are offered two modern expensive vaccines (one against typhoid and one against hepatitis A), which together cost the NHS about £32. Several other vaccines may also be offered. The conditions prevented are much less common among travellers than malaria, often less serious (typhoid, hepatitis A), and sometimes vanishingly rare (rabies, Japanese B encephalitis, noncutaneous diphtheria).[2] Cost-benefit analysis has shown that, in contrast to malaria prophylaxis, none of these vaccines is a sensible investment for public health resources,[3] though individual people may reasonably wish to purchase their own protection.

Illness among travellers is extremely common, but diseases that are preventable by vaccination are a minute part of the problem. Unfortunately, the provision of vaccines, driven by the present funding arrangements, dominates the interaction between travellers and the health services to the exclusion of important public health messages that might limit conditions that are both serious (road traffic accidents, malaria, infection with sexually acquired viruses) and much more common (travellers' diarrheoa, severe sunburn).

GUY BALLY
Senior registrar

Department of Infectious Diseases and Tropical Medicine,
North Manchester General Hospital,
Manchester M8 5RB

1 Hollyoak V. Prophylaxis against malaria. *BMJ* 1995;310:1329. (20 May.)
2 Steffen R. Hepatitis A and hepatitis B: risks compared with other vaccine preventable diseases and immunization recommendations. *Vaccine* 1993;11:518-20.
3 Behrens RH, Roberts JA. Is travel prophylaxis worth while? Economic appraisal of prophylactic measures against malaria, hepatitis A, and typhoid in travellers. *BMJ* 1994;309:918-22.

Proportions of 11-15 year old respondents in successive cross sectional surveys who had never smoked, 1982-92 (taken from Thomas et al[2])

	1982	1984	1986	1988*	1990	1992
		England				
Boys:						
No of respondents	1514	1689	1676	1489	1643	1662
% (No) who had never smoked	45 (681)	45 (760)	55 (922)	58 (864)	56 (920)	57 (947)
Girls:						
No of respondents	1514	1689	1508	1529	1478	1626
% (No) who had never smoked	49 (742)	46 (777)	53 (799)	59 (902)	58 (857)	57 (927)
		Scotland				
Boys:						
No of respondents	1190	1365	1169		1359	1489
% (No) who had never smoked	37 (440)	39 (532)	50 (585)		49 (666)	52 (774)
Girls:						
No of respondents	1095	1408	1190		1317	1411
% (No) who had never smoked	41 (449)	40 (563)	45 (536)		49 (645)	45 (635)

*Scotland was not included in survey in 1988.

What happened to care?

EDITOR,—Ian Capstick complains that neither "hospital trusts nor the Department of Health seem to recognise the need for a national policy for those who cannot be cured, based not on cost but on patients' wishes."[1] I agree that there is a tendency in the NHS to think of nothing but costs and quantities. On my office wall I have a copy of Mahatma Gandhi's talisman: "Whenever you are in doubt or when the self becomes too much with you apply the following test. Recall the face of the poorest and the weakest man whom you may have seen and ask yourself if the step you contemplate is going to be of any use to him. Will he gain anything by it? Will it restore him to control over his own life and destiny? . . . Then you will find your doubts and yourself melting away."

I find this quite a good test of whether a decision or action is going to serve people with problems or serve those in power.

C J BURNS-COX
Consultant physician

Directorate of Medical Services,
Frenchay Hospital,
Bristol BS16 1LE

1 Capstick I. What happened to care? *BMJ* 1995;310:742. (18 March.)

Correction

Future of intensive care

Several editorial errors occurred in this letter by Ian S Grant (20 May, p 1335). The second author of the letter, Dr R J Winter, consultant intensive care specialist at Queen's Medical Centre in Nottingham, was omitted. Dr Grant's position was wrongly given: he is medical director of the intensive therapy unit at Western General Hospital. Also, the last sentence should read: "Intensive care must be recognised as a distinct specialty and the royal colleges must establish an intercollegiate faculty to [not or, as published] facilitate reorganisation, formalise training, and stimulate academic activity in intensive care with the utmost urgency."

Genetic testing for familial hypertrophic cardiomyopathy in newborn infants

A typesetting error occurred in the second letter in this cluster, by Theresa Marteau and Susan Michie (1 July, pp 58-9). The ninth sentence of the second paragraph should read: "The mother in our study reported being less rather than more protective, in that she was less anxious [not 'in that she was anxious'] about insisting on early bowel screening for her children after receiving the results."