smoking is considerable²; 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,³ however, reflects much sociological work⁴ 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 antismoking 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.¹ 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.² 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.³

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.¹ 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,"^{1,2} may undermine the advice given by the chief medical officer in 1988 in relation to meningococcal infection.³ 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.^{4,5}

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- 1 Minerva. *BMJ* 1993;306:154. (9 January.)
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Organ donation

EDITOR,—We support several of the points in R M R Taylor's editorial on organ donations.¹ 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.² 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).³ 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.)
- 2 Feest TG, Riad HN, Collins CH, Golby MGS, Nicholls AJ, Hamad SN. Protocol for increasing organ donation after cerebrovascular deaths in a district general hospital. *Lancet* 1990;335:1133-5.
- 3 Bodenham A, Berridge JC, Park GR. Brain stem death and organ donation. *BMJ* 1989;299:1009-10.

EDITOR,—G R Park and colleagues express grave reservations¹ about the Exeter protocol for elective ventilation of potential organ donors.² Without

defining ethics, they believe that we have been acting unethically: they describe a typical case in which elective ventilation might be considered—a patient with a clearly diagnosed fatal cerebral injury who undergoes respiratory arrest. They write, “Deliberately prolonging a patient’s dying is unacceptable for any reason.” But such patients die when breathing ceases; elective ventilation does not prolong the act of dying, for one is ventilating a corpse. If that is wrong, let them tell us why, rather than differentiate between dead bodies on the basis of whether a diagnosis was made before or after death, or whether the patient stops breathing in the accident and emergency department rather than a medical ward.

We were taxed by ethical issues when we set up the elective ventilation protocol: ethics may be defined as what is right, and in turn that can be regarded as behaviour that causes no distress, offence, or indignity in the context of current societal values. To act ethically, firstly, we must respect the wishes of the dead and dying; secondly, we must cause no unnecessary distress to relatives; and, lastly, we must cause no emotional crisis for the staff of intensive care units. We know from many surveys of public opinion that over 70% of the public would wish their organs to be used for transplantation after death. In our unit one of the goals of elective ventilation is the respecting of these wishes.

It seemed to us illogical that patients who stop breathing before irreversible brain injury is diagnosed can become organ donors, whereas clinically identical patients who become apnoeic after diagnosis cannot. Such patients often differ only in the time taken to reach hospital, and to claim that they differ in any more fundamental way is pure sophistry. It is hard to see how the denial of a patient’s right to be an organ donor after death is ethical behaviour. The relatives of our electively ventilated organ donors do not feel that we act improperly; rather, they all consider that the process of organ donation allows them to make some sense of an otherwise inexplicable loss.³

It is sad that Park and colleagues have not understood the logical and moral basis of elective ventilation. We welcome this opportunity to restate our position and encourage other units to follow our lead.

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- 1 Park GR, Gunning KE, Lindop MJ, Roe PG. Organ donation. *BMJ* 1993;306:145. (9 January.)
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Death rate from asthma

EDITOR,—Our experience supports W T Berrill’s conclusion that the death rate from asthma may be exaggerated.¹ In East and North Hertfordshire (estimated population 480 000) during 1986-91 inclusive, 114 deaths from asthma at all ages were reported by the Office of Population Censuses and Surveys. Even if the contribution of bronchial asthma to cause of death is interpreted generously—for example, part I of the death certificate states death from asthma and part II states chronic obstructive airways disease—only 63 of 100 deaths have so far been found to be attributable to asthma. Fourteen sets of records remain to be examined. The number of deaths in people aged over 65—22 of the 63—reduces the potential for saving lost

years of life. Only 19 of the 63 deaths occurred below the age of 45.

Taking into consideration the circumstances in which many of these deaths occurred, we believe that there will be only a small health gain from reducing mortality. We are therefore shifting some of our attention to exploring the opportunities for reducing morbidity. Meanwhile it would be of great help if the accuracy of death certification could be improved, possibly through audit. Initiatives to improve understanding of the burden of ill health due to asthma would be welcome.

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- 1 Berrill WT. Is the death rate from asthma exaggerated? Evidence from West Cumbria. *BMJ* 1993;306:193-4. (16 January.)

EDITOR,—W T Berrill implies that death should not be attributed to asthma in older people (over the age of 60) because asthma is “a disease of young people.”¹ Not only is reversible airways disease common in older adults² but, as with most other conditions, older people are probably more likely to die of it than younger people. Thus most people dying of asthma should be expected to be old.

Because of the underappreciation of asthma in elderly people such patients are treated with antibiotics for their respiratory infections but are left to suffer the dyspnoea and hazards of their respiratory obstruction.

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- 1 Berrill WT. Is the death rate from asthma exaggerated? Evidence from West Cumbria. *BMJ* 1993;306:193-4. (16 January.)
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Epidural analgesia in labour

EDITOR,—An item by Minerva may mislead readers.¹ It states that epidural analgesia with bupivacaine is associated with factors that adversely affect the infant, such as lower maternal self esteem, prolonged labour, use of oxytocin, and forceps delivery. No randomised study has ever shown that these negative aspects of childbirth are a result of epidural analgesia.

The study to which Minerva refers, by Sepkoski *et al*, compared women who received epidural analgesia, without randomisation, with poorly matched controls who had no pain relief; matching was based on criteria expected to affect the placental transfer of the local anaesthetic bupivacaine.² An attempt to match for the duration of the first and second stages of labour, the use of oxytocin, and the mode of delivery failed. The authors assume that these are a direct result of epidural analgesia and refer to work in which, again, randomisation was not done. It is not surprising that the women who had epidural analgesia had significantly longer labours, a greater requirement for oxytocin, and a higher rate of instrumental delivery as such factors increase the need for epidural analgesia and therefore cannot be assumed to result from it. Moreover, they may themselves affect neonatal behaviour and interaction between the mother and her infant. Non-randomised comparisons of epidural analgesia with no analgesia or other forms of pain relief are likely to be biased since those women experiencing long, difficult labours are more likely to request epidural analgesia.

Sepkoski *et al* used 0.5% bupivacaine in their study. This high concentration is unnecessary and

not standard practice in Britain as it results in an appreciable motor block, which impairs maternal satisfaction.³

There are studies in which neonatal assessment has been made after attempts at randomisation of analgesia during labour. In one, no adverse effects on neonatal outcome were found.⁴ Other studies that were not randomised failed to show adverse effects on the baby. Indeed, in many studies epidural analgesia has been shown to be beneficial. Kangas-Saarela *et al* found that babies whose mothers had received epidural analgesia with bupivacaine had higher neurobehavioural scores than those whose mothers had not received such analgesia.⁵ Two other studies showed no adverse effects of epidural bupivacaine in labour on neonatal neurobehavioural scores.^{6,7}

Minerva should take the scientific methods used in papers into consideration. This would prevent questionable findings influencing a much wider readership.

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- 1 Minerva. *BMJ* 1992;305:1514. (12 December.)
- 2 Sepkoski CM, Lester BM, Ostheimer GW, Brazelton TB. The effects of maternal epidural anaesthesia on neonatal behavior during the first month. *Dev Med Child Neurol* 1992;34:1072-80.
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Thromboembolic complications of laparoscopic cholecystectomy

EDITOR,—The incidence of deep venous thrombosis and pulmonary embolism in diagnostic laparoscopy is low. It was reported as 0.2 cases/1000 procedures in a confidential inquiry into 50 427 gynaecological laparoscopies.¹ In a single report of 100 laparoscopic salpingectomies deep venous thrombosis occurred in one patient.² Concern has been raised, however, about the increased potential for thromboembolism in patients undergoing laparoscopic cholecystectomy.³ The true incidence of thromboembolism in this procedure is not known.

We have performed laparoscopic cholecystectomy on 438 patients, and thromboembolism has occurred in three: one deep venous thrombosis, one non-fatal pulmonary embolism, and one fatal pulmonary embolism. All three cases were confirmed by phlebography or ventilation-perfusion scanning or after death. Interestingly, two of the cases were diagnosed within four days of surgery, and both patients had been mobile up to the day of surgery. All three patients received prophylaxis with subcutaneous heparin and compression stockings. The patient with the deep venous thrombosis also had intraoperative stimulation of the calf. We believe that thrombosis of leg veins or pelvic veins occurred intraoperatively, accounting for the early presentation in two of the patients.