Van der Sijs-Bos and colleagues claim that our evidence is insufficient to challenge the specificity of prenatal diagnosis of Turner's syndrome karyotypes made by amniocentesis, but at the same time they present data that point in the same direction as our data.

We must re-emphasise the conclusion of our paper: the only study that will resolve this question is one looking at every fetus with a prenatal diagnosis of a Turner's syndrome karyotype, with special reference to the distribution of cells in cases of mosaic karyotypes, results from karyotyping of aborted fetuses, and karyotyping of infants with the syndrome who have not yet been examined postnatally.

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Vietnamese people in study may have had language difficulties

EDITOR,—J Atri and colleagues report that Chinese and Vietnamese adults living in Tower Hamlets, inner London, were the least likely of the ethnic groups studied to have all aspects of preventive care recorded in their general practice records.¹ Although these differences were significant only for the recording of family history and weight, the universality of these findings contrasts with the findings for all the other ethnic groups surveyed.

In Nottingham a structured interview survey of 135 Vietnamese adults has recently been completed (response rate 92%). Interviews were conducted in either Cantonese or Vietnamese, and over one third of local Vietnamese residents were directly represented.² Altogether 82 of 134 interviewees spoke only a few words of English or none at all; not surprisingly, a large proportion also reported difficulty in deciding when to attend their general practitioner (56/130), making the appointment (61/130), explaining to the doctor what was wrong (86/129), and understanding any advice given (90/130). Almost half (61/130) had decided, on at least one occasion, not to visit their general practitioner because of language difficulties.

We believe that these data help to explain why the levels of preventive activity recorded for Vietnamese people in Tower Hamlets may have been so low. Further initiatives are needed to make local health care services easier for Vietnamese people to use, especially with regard to communication with members of the primary health care team. It is a popular misconception that Vietnamese people have adapted easily to life in Britain and therefore require little special attention from health professionals.

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1 Atri J, Falshaw M, Livingstone A, Robson J, for Healthy East-enders Project. Fair shares in health care? Ethnic and socioeconomic influences on recording of preventive care in selected inner London general practices. *BMJ* 1996;312:614-7. (9 March.)

2 Nguyen-Van-Tam JS, Simpson J, Madeley RJ, Davies LM. Health care experiences of Vietnamese families in Nottingham. *Health Trends* 1995; 27:106-10.

Smoking in public places

Restaurants' policies do not reflect public's preferences

EDITOR,—Simon Chapman's call for political will and legislation to curb smoking in restaurants will strike a chord with all agencies involved in reducing the harm from passive smoking.¹ The public's attitude on this issue is clear. A lifestyle survey conducted in Solihull showed that nearly half of the district's residents preferred smoking to be banned in restaurants and a similar number preferred smoking to be restricted to certain rooms.²

Table 1—Management policy on smoking in 40 restaurants in Solihull

Policy	No of restaurants
No smoke free areas	25
Some smoke free areas:	
<33%	2
33-50%	3
50-75%	5
≥75%	1
Smoke free areas separate and ventilated	2
Completely smoke free	2

I conducted a telephone survey of restaurants in Solihull to ascertain smoking policies and to see whether they reflected the public's preferences. I randomly selected 40 restaurants in the borough and asked the managers to state their policy on smoking on their premises. Nearly two thirds of the restaurants had no effective operational policy on smoking (table 1). Most of the managers claimed that a policy to restrict smoking would result in a decrease in their revenues, though there is no published evidence to back this claim.¹ The management policies do not reflect the public's strong preference for restrictions on smoking in restaurants. My survey has highlighted the huge public health task of making restaurants into smoke free zones.

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1 Chapman S. Smoking in public places. *BMJ* 1996;312:1501-2. (27 April.)

2 Solihull lifestyle survey: annual report of the director of public health for Solihull 1991. Solihull: Solihull Health Authority, 1991.

Vast majority of both smokers and non-smokers favour at least a partial ban

EDITOR,—Simon Chapman highlights the growing support for smoke free public areas.¹ It is important to note that most smokers also support such measures. A recent lifestyle survey in Solihull (part of the west midlands 1995

health survey) asked 3000 residents for their opinions on smoking in various public places. Table 1 shows the responses of both smokers and non-smokers. The vast majority of both smokers and non-smokers were in favour of at least a partial ban on cigarette smoking in most public places. Even in pubs, where, as would be expected, few smokers favoured a complete ban, over half of them agreed with partial restrictions. Almost all smokers and non-smokers thought that smoking should be banned in schools. Perhaps these results are linked to a belief that stopping smoking is easier in a smoke free environment: three out of every four smokers expressed a wish to give up smoking.

Results such as these should be used to counter any propaganda from the tobacco industry suggesting that legislation to encourage smoke free areas would be against the interests of smokers.

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1 Chapman S. Smoking in public places. *BMJ* 1996;312:1051-2. (27 April.)

Medical students do not think they have authority to advise patients to stop smoking

EDITOR,—We wish to report a study of the prevalence of smoking among medical students at the University of Manchester Medical School and the students' attitudes towards advising patients to stop smoking. Self administered questionnaires were completed by 621 undergraduate medical students (292 men and 329 women; response rate 57%) from all five years of the medical course. The anonymous questionnaires were distributed to first, second, and third year students during a class; completed during breaks between lectures; and collected at the end of the teaching session. The questionnaires were posted to fourth and fifth year students, who were on clinical practice in hospitals and posted them back.

Altogether 67 (23%) of the men and 51 (16%) of the women currently smoked cigarettes; this was a higher prevalence than in 1981 (when it was 18% and 15% respectively).¹ The highest prevalence of smoking was found in students from the south of England (22/67 (33%) for men and 22/86 (26%) for women), and the prevalence was higher in students from non-manual than manual backgrounds (56/236 (24%) for men and 46/285 (16%) for women v 3/37 (8%) and 3/29 (10%) respectively). Levels of stress and self esteem were not significantly associated with smoking. The most interesting findings were the students' perceptions of their roles with regard to smoking. Sixteen (24%) male smokers and 20 (39%) female smokers compared with 230 (52%) of the non-smokers

Table 1—Number (percentage) of smokers and non-smokers who supported complete or partial ban on cigarette smoking in various public places*

Location	Smokers (n = 793)		Non-smokers (n = 2503)	
	Complete ban	Partial ban	Complete ban	Partial ban
Public transport	461 (61)	256 (34)	2088 (86)	311 (13)
Restaurants	208 (27)	510 (66)	1617 (66)	780 (32)
Pubs	47 (6)	537 (59)	659 (28)	1440 (61)
Cinemas	479 (63)	236 (31)	2034 (84)	337 (14)
Workplaces	188 (26)	474 (64)	1388 (58)	907 (38)
Schools	660 (87)	75 (10)	2257 (93)	117 (5)
Colleges	482 (64)	241 (32)	1896 (79)	464 (19)

*Some respondents did not answer every question.

Table 1—Respondents' opinions on advising people to stop smoking. Figures are numbers (percentages) of respondents who agreed with each statement

	Year of medical course					Smoking behaviour		
	1 (87 men, 67 women)	2 (40 men, 59 women)	3 (59 men, 84 women)	4 (57 men, 76 women)	5 (49 men, 45 women)	Non-smoker (197 men, 245 women)	Ex-smoker (28 men, 33 women)	Current smoker (67 men, 51 women)
Medical and nursing students have knowledge to advise patients to stop smoking								
Male	52 (60)	32 (80)	42 (72)	47 (83)	38 (78)	142 (72)	19 (68)	50 (76)
Female	38 (58)	34 (61)	55 (66)	63 (84)	37 (82)	173 (71)	24 (73)	30 (60)
Medical and nursing students have authority to advise patients to stop smoking								
Male	28 (32)	16 (40)	22 (38)	17 (30)	31 (63)	85 (43)	11 (39)	18 (27)
Female	18 (27)	20 (36)	29 (35)	33 (43)	16 (36)	90 (37)	12 (36)	14 (28)
One individual has right to advise another to stop smoking								
Male	64 (74)	30 (75)	39 (67)	40 (70)	41 (84)	155 (79)	18 (64)	41 (62)
Female	41 (61)	33 (59)	62 (74)	55 (72)	32 (71)	178 (73)	18 (55)	27 (54)

agreed that doctors and nurses should not smoke ($P = 0.012$ for women and $P < 0.001$ for men). As table 1 shows, however, while most students in all years agreed that they had the knowledge to advise patients to stop smoking, they were far less likely to agree that they had the authority to do so. Surprisingly, few students disagreed with the statement that one person has the right to advise another person to stop smoking.

Our findings show that the prevalence of smoking among medical students may be rising. Students seem to perceive their student status as impeding them from advising patients and others about stopping smoking. The problem based curriculum that is now in place will help students to develop the skills and confidence needed to overcome these reservations. Doctors' advice to patients with regard to stopping smoking has been shown to be effective,^{2,3} so it is important that these issues should be covered in medical courses and that newly qualified doctors should emerge with knowledge and confidence to carry out this important task.

We thank the Cancer Research Campaign and Japanese Ministry of Education for financial support and Dr Ann Cockcroft, of the Royal Free Hospital, London, for help with the questionnaire.

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- Knopf Elkind A. Changes in the smoking behaviour, knowledge and opinions of medical students 1972-1981. *Soc Sci Med* 1982;16:2137-43.
- Russell MAH, Wilson C, Taylor C, Baker CD. Effect of general practitioners' advice against smoking. *BMJ* 1979;iii:231-5.
- Campbell IA, Lyons E, Prescott RJ. Stopping smoking: do nicotine chewing-gum and postal encouragement add to doctors' advice? *Practitioner* 1987;231:114-7.

Making decisions with children

Asking children to participate in decisions about their care undermines parents' position

EDITOR,—It is clear from his editorial advocating that children should participate in decisions about their care that George Rylance has not the remotest idea of what is involved in the day to day care of children in a surgical context, where issues of consent most commonly arise.¹ The extraordinary proposals outlined in his editorial

and in the Institute of Public Policy Research's document from which he quotes—that consent independent of that of the parents should be obtained from the child for virtually every procedure carried out in hospital, from being weighed and measured onwards—would unleash a cocktail of bureaucracy, litigation, and time wasting in attempts to give children total authority in every procedure proposed for them in a hospital. This pernicious philosophy comes from the same stable as that which presumes all parents guilty of injury or abuse of their children until proved otherwise. Like that doctrine—of whose disastrous results we are painfully aware—it weakens the position of parents by denying that they are the people closest to their child and in the vast majority of cases have the child's best interest at heart (more so even than the paediatricians do) and are therefore in the best position to translate and explain a doctor's properly given advice.

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Author's reply

EDITOR,—I expected that the code of practice suggested by the Institute of Public Policy Research might be seen by some doctors to be extreme, impracticable, and potentially time wasting. It seems, however, to be a logical extension of the practice of talking with child patients, giving explanations and advice, and involving them in decision making. It is apparent that not all doctors believe in this approach. Adult patients usually have the power to argue their rights and make clear their needs and demands. Children who are recognised to be competent to share in and make decisions have similar rights to adults, but the paternalistic attitude of some doctors and the imbalance of power in doctor-patient relationships make it necessary for others to speak up for children and their rights.

The code of practice represents a framework within which doctors, children, and parents can work together in making health care decisions. It in no way seeks to separate a child's decision making process from that of the parents but recognises the need for children to be treated as individuals capable of considering options and making decisions about their care.

I am aware that the suggested approach may produce difficulties, and debate about it is essential. Nevertheless, I think that P J Mahaffey's concerns are exaggerated. My work, like that of most paediatricians, entails much decision making with children and parents each day, albeit not usually concerning consent to surgery. I have practised over a number of years in a manner

broadly similar to that suggested by the Institute of Public Policy Research and have not recognised any particular difficulties. Many adult and child patients report that there has been inadequate information, explanation, and discussion in their consultations with doctors, and this is clearly unsatisfactory. I hope that children's fundamental needs and rights will not be further denied by spurious concerns about increased bureaucracy, time, and litigation.

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Volunteering children for bone marrow donation

Studies show large discrepancies between views of surrogate decision makers and patients

EDITOR,—The articles on the ethics of volunteering children for bone marrow donation raise several issues about proxy or surrogate decision making.¹ The central issue concerns the identification of the donor's and family's best interests, when the decision maker must determine the highest benefit from available options.

Although many philosophical questions are involved, there are also empirical questions to be asked. The validity of surrogate decision making rests on the assumption that the decision maker can gauge the individual's needs, views, or interests with some accuracy, or at least with more accuracy than others. Julian Savulescu argues that "parents know their children better than social workers, who are poorly placed to know what kind of family they are, how close they are."² Some studies have compared the views of health care professionals and parents with those of patients and children. Do parents and professionals get it right?

Many studies have shown that there can be a large discrepancy between the views and experiences of potential surrogate decision makers and adult patients.^{2,3} Generally speaking, professionals underestimate the levels of pain or distress, and the discrepancy can be large. Other patients are sometimes more accurate at identifying difficulties than professionals. While there are fewer studies comparing parents' and children's views, a similar pattern emerges. For example, there can be very low agreement between parents' and child patients' views of psychiatric treatment, with parents underestimating the child's feelings of distress, anxiety, and negative reactions.⁴ In a study on perceptions of pain, nurses', parents', and children's own reports during venepuncture were compared. The correlation between parents' and their child's ratings of pain was modest, and, contrary to Savulescu's contention, nurses were better at estimating children's discomfort than were parents.⁵