interviews, which had been placed in the "lonely hearts" or "contact" sections of local and national newspapers and magazines. The sample came from 107 of the 120 postal districts in Britain. The age range was 16-73 (mean 33.3 (SD 8.7) years), with only 148 coming from social and occupational classes 1 and 2.

Preliminary analysis shows that 644 reported having had sexual contact with men and women in the year before the interview (mean three male and three female partners). Six hundred and ninety nine reported vaginal intercourse with a female partner, of whom 502 had not used a condom. Four hundred and sixty one reported anal intercourse with male partners, of whom 135 had not used a condom. Five hundred and thirty one reported that they currently had a regular female partner, but only 233 currently had a regular male partner. One hundred and seventy four had both female and male regular partners. Almost all the respondents' regular male partners (203) knew of their sexual activity with women, but only a third (144) of their regular female partners knew of their homosexual activities.

Considerable potential exists for the spread of sexually transmitted diseases within and by this population, with its high numbers of partners and appreciable rate of unprotected anal and vaginal intercourse. The extent to which HIV will spread within this population depends crucially on the patterns of sexual contact with existing core groups (especially gay men).

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Protecting children in cars from tobacco smoke

EDITOR,—There is considerable evidence that exposure of children to environmental tobacco smoke is associated with an increase in morbidity in those with pre-existing asthma and an increase in the number of new cases of asthma.^{1,2} In Australia, accreditation standards for child care now require that day care centres be smoke free,³ and nearly one in four smokers report voluntarily smoking only outdoors at home.⁴

While the state regulates many aspects of the domestic environment (for example, electrical and building standards, smoke detectors), there are few precedents for the regulation of personal behaviours such as smoking in homes (although sexual and violent behaviour towards children is outlawed in many countries). When adults smoke in the enclosed, confined interiors of cars small children who are passengers are involuntarily exposed to often prolonged, concentrated volumes of environmental tobacco smoke. To our knowledge, public support for the regulation of smoking in cars has never been measured in any country.

To test community support for the banning of smoking in cars while children are passengers we conducted a random household survey, using standard methods for assessing the prevalence of smoking and attitudes.⁵ The survey was conducted throughout New South Wales, Australia, in

November 1994. Altogether 1461 people aged 18 and over were asked "Do you think it should be illegal to smoke in cars when travelling with children?" A total of 1048 (72%) respondents agreed, 396 (27%) disagreed, and 17 (1%) were undecided. There were no significant differences in responses by age, educational attainment, country of birth, city or rural residence, or employment status. A higher proportion of women (556/735 (75.6%)) than men (492/709 (69.4%)) agreed with the proposal ($\chi^2=6.78$, $df=1$, $P=0.009$). Two hundred and sixty two (63%) of 413 current smokers also agreed.

The compulsory fitting and use of car seat belts and infant restraints are obvious precedents in terms of the state interceding in the private conduct of parents in cars. Use of seat belts is enforced in Australia by opportunistic police checks and penalties, with the result that compliance with the law concerning seat belts is consistently higher than 95%. The strong community support shown in our survey for a ban on smoking in cars carrying children could give rise to similar compliance.

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Obtaining insurance should not depend on mechanism of diagnosis tests

EDITOR,—In his editorial on the parliamentary report *Human Genetics: the Science and its Consequences*, Peter Harper reports sharp criticism of insurance companies, but fails to clarify the grounds for complaint.¹ He seems to imply that insurance companies should not take into consideration the results of genetic tests that are known to the patient. It is difficult to discern the reasoning for differentiating between genetic and conventional predictive tests.

Take two examples, Huntington's disease and polycystic disease of the kidneys. These are both autosomal dominant conditions with a major impact on mortality in middle age. For Huntington's disease a highly accurate genetic test exists; for polycystic disease, ultrasound scanning can be almost as accurate, and in time, presumably, a genetic test will become available for this condition too. If access to results of genetic tests is forbidden, proposers with Huntington's disease and a positive result will obtain insurance while proposers with polycystic disease and positive findings on ultrasound scanning will not (until a genetic test is developed for the condition). This is

inequitable. The ability to obtain insurance should not depend merely on the mechanism of a diagnostic test.

Without medical underwriting voluntary insurance schemes will not survive because of the adverse selection they will face. Therefore, one accepts compulsory schemes, such as national insurance, or allows the principle of underwriting, or both, as currently in Britain.

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Effects of helicopter service on survival after trauma

Service is part of a continuum of care

EDITOR,—In their study of the London helicopter emergency medical service J P Nicholls and colleagues failed to take account of a fundamental aspect concerning the potential added value of such a service.¹ In patients with trauma medical interventions before admission to hospital are generally most effective in reducing mortality and improving long term outcome if a continuum of medical care from resuscitation to definitive surgery and rehabilitation is in place.² The London helicopter emergency medical service together with related developments at the Royal London Hospital enables such care to be provided because of the integration of the various elements into a trauma system. Patients transported by other means or to other accident and emergency departments in London (even if by helicopter) are not necessarily assured of this continuum of care because of the following factors: long transfer times without adequate continuing resuscitation, inappropriate triage to hospitals that lack relevant medical specialties on site, and an inexperienced and inadequate medical response that fails to provide timely, definitive care when the patients arrive at those hospitals.^{3,4}

Despite matching for severity of injury, the authors' study may have underestimated the effectiveness of the London helicopter emergency medical service by including, in the helicopter cohort, patients taken to other hospitals and by simultaneously reducing the proportion recruited from the Royal London Hospital. A more valid study would have compared patients taken by the London helicopter emergency medical service to the Royal London Hospital with a matched control group taken by land based paramedics to either the same or another major accident and emergency department.

Although the trial involving American helicopter services that the authors cite failed to show significantly improved outcomes in patients, this should be interpreted in the context of the superior land based ambulance services and hospital based trauma services in the United States compared with London.⁵ In such settings it is not surprising that helicopter based services provide little added benefit.

Until the standard care provided for patients