sion in saying that I really do think it unfair that when our patients think they need a thorough health check-up they ask their *doctor to vet* them, but when they want their cats castrated they ask the *vet to doctor* them. No doubt there is an obvious Freudian explanation which has escaped me.

Is it unrealistic to hope that the *BMJ* will lead the profession back to a dignified world where it is the patients who are doctored and the moggies who are vetted and not vice versa?

D R LAURENCE

Department of Medicine,
University College Hospital
Medical School,
London WC1E 6JJ

"Outwith my competence"

SIR,—As an honours graduate in English, with more than a passing interest in the development of our native tongue, I was most interested to read Mr Karl Sabbagh's letter on the use of the word "outwith" (31 March, p 894). In fact, only days earlier I had been discussing this word with a colleague who has recently joined the BMA staff and who, like myself, had not encountered it (dare I say) outwith the medicopolitical field.

I do not entirely agree with the Editor's footnote regarding the wide usage in educated speech in Scotland and Northern Ireland as this implies it has not yet penetrated the rest of the UK. Surely he cannot have failed to hear the favourite recourse of the harassed at BMA House: "This is outwith my remit" (the latter word also, perhaps, being fodder for further debate). It sounds so much more educated than saying: "It's not my job," which, these days, smacks of demarcation lines; it looks better on paper and it completely baffles the uninitiated.

Mr Sabbagh, I share the fear which induced you to pen your letter. What unnecessary and meaningless *inroads* are being made on our language *at this point in time*.

SUE HICKENBOTTOM

BMA North-west Regional Office,
Manchester M14 5RH

SIR,—I am amazed at your editorial comment (31 March, p 894) that the word "outwith" is widely used in Northern Ireland. During the whole of my life there I have never heard it spoken, except occasionally by an immigrant Scot. I trust that you will speedily remove your imprimatur.

H G CALWELL

Carrickfergus,
Co Antrim BT38 9QP

Bicycle accidents

SIR,—I bought a bicycle at Christmas and have become very much addicted to it. I therefore read the letter of Mr H Milnes Walker (10 February, p 413) with considerable interest. I too have been very apprehensive of following traffic and entirely confirm the difficulties he mentions.

Unfortunately, when I have tried to look backwards I have found I tend to swerve into the road. I tried a bicycle mirror but have found it very difficult to obtain a fitting, particularly because the position of the supporting arm from the handlebars is quickly jerked out of alignment when the bicycle goes

over a pothole. I tried therefore carrying a mirror on the back of my right hand. I have used simple Velcro straps, fastened for the time being with Araldite to the back of the mirror, to hold this to the back of my hand. I find I can use this pretty well to check the position behind me, though a little practice is required and inspection has to be rather deliberate. The mirror I have used is a two-plane panoramic one, though a simple plain mirror may in fact be better and I will experiment with this.

I wonder if other cyclists among your readers might be interested in the idea and whether some commercial firm would think that it were worth while to put such a device into production, perhaps with a rather improved hand grip.

K NORCROSS

Department of Accident Surgery
and Orthopaedics,
Dudley Road Hospital,
Birmingham B18 7QH

Judging safe distances

SIR,—Your special correspondent on road accidents correctly refers to the difficulty of judging safe distance for drivers (2 December, p 1551). This difficulty derives from the fact that safe distances vary with different speeds. Perceptual errors associated with this task are well known.

A preferable solution is to teach drivers to keep an interval measured in time rather than seconds from the vehicle in front of their vehicle. The two-second interval ("one thousand one, one thousand two") eliminates the need for a relatively complex split-second calculation of desired *distance* and gives the driver a simple rule for training and monitoring his distance from cars ahead of him.

Education involves knowledge, attitude, and practice. The two-second interval rule simplifies the complexity of the driver's task in relation to two of these three elements: knowledge and practice. It would be helpful to know if there have been controlled trials of the effect of teaching the two-second rule on driver behaviour with regard to headway.

ELIHU D RICHTER

Department of Medical Ecology,
Hadassah Medical School,
The Hebrew University,
Jerusalem, Israel

Use of car headlamps

SIR,—Mr John Primrose (31 March, p 891) is critical of the need for the more widespread use of car headlamps in conditions of poor visibility and in urban areas after dark. He stresses the problem of dazzle to other car users because of reflection and the masking of direction indicator lights by headlamp glare. While I accept both these points neither is an adequate argument against the use of correctly aligned and dipped headlamps, but they perhaps suggest that the design of headlamps and direction indicator lamps could be improved.

The legal requirements for headlamp and fog lamp use in fog, snow, and heavy rain are clearly given in *The Highway Code*; and we are also advised to use dipped headlamps in urban areas at night where the street lighting is inadequate, as it often is. A glance at the table of factors contributing to road accidents,¹ compiled from data obtained by the Transport

and Road Research Laboratory, will show that "looked but failed to see" and "failed to look" are both common contributory factors in accidents involving cars and pedestrians. Mr Primrose's comment "It is not so much requiring to be seen as being able to see anything else" typifies the selfish attitude of many drivers who think that if they can see the road ahead without using headlamps then other road users can see their approaching car. "I just did not see him" is a common statement after an accident. If we use our headlamps more readily when driving in rain, fog, and snow and at night we must be more easily seen—and this must reduce the number of accidents.

Mr Primrose's "rally drivers" cannot be condoned for acting illegally. Low-slung fog lamps can be used only in fog or snow; spotlamps, which operate on main beam, must be fitted in pairs or in conjunction with a fog lamp and must be wired in such a way as to be operational only when headlamp main beam is on.

Finally, I must strongly disagree with the suggestion that flashing headlamps as a warning at crossings or other danger spots is to be recommended. Headlamp flashing is an often misinterpreted signal and could lead to accidents at junctions. Distraction is also a common contributory factor to accidents,¹ and flashing headlamps could distract. As most instantaneous headlamp flashers operate only on main beam the chances of temporarily blinding drivers of oncoming cars and thus increasing the risk of an accident is surely greater than if we merely used dipped headlamps.

DERRICK MARTIN

Department of Medicine,
Withington Hospital,
Manchester M20 8LR

¹ *British Medical Journal*, 1978, 2, 1272.

Why blame the obstetrician?

SIR,—Professor Ronald Illingworth (24 March, p 797) deplores the "sale of goods act" attitude that a parent who orders a baby through the health service should be entitled to claim compensation from his obstetrician (as retailer) if the product proves of "un-merchandiseable quality." The message from his review is that blame in most cases should more properly be laid at the door of the manufacturer. In the field of man-made consumer products this is of course a well-known area of dispute. In reproductive medicine it is one on which the pathologist, as a quality control specialist, may be expected to comment.

The two major forms of pathology which are commonly accepted to have preventable aspects are birth trauma and perinatal asphyxia. Severe birth trauma is, however, believed to be rare.¹ It is not widely appreciated that it may be almost as difficult to recognise trauma at post-mortem examination of the newborn as in life. The difficulty of examining the soft unmyelinated brain, particularly that of the preterm infant, means that trauma is only commonly diagnosed if associated with massive haemorrhage or disruption of cranial structures. Although tentorial tears would be recognised by most pathologists, the common and potentially fatal (or damaging) lesion of separation of the squamous and lateral parts of the occipital bone appears to have been consistently overlooked for many

years until our own recent study.² Lesions of this type occurring in preterm infants may not be associated with massive subdural haemorrhage. This alone suggests that the reported incidence of intracranial birth trauma is a gross underestimate.

The forms of damage seen most frequently in the normally formed newborn brain at necropsy are vascular lesions involving haemorrhage or ischaemic necrosis.³ Such damage, if not manifestly of traumatic origin, is usually ascribed to "anoxia," as is cerebral palsy in survivors. Anoxia is indeed the final mechanism leading to almost all forms of death, but would hardly be accepted as an adequate explanation for adult deaths due to strangulation, coronary thrombosis, or lung cancer.

If the clinician (be he obstetrician or paediatrician) wishes to solve the problems of the causation of cerebral palsy he will have to gain a greater awareness of the danger of cranial birth trauma and must begin to take the cerebral circulatory physiology of the fetus and newborn infant seriously. He will need to consider the implications of pressures and flows in the cerebral circulation and the effects on them of changes in cranial pressure, arterial pressure, and acid-base status. Until he does so, there is perhaps some basic logic in the attitude that he is to blame for brain-damaged babies. If the defects are all the fault of the manufacturer it is incumbent on the retailer to prove it.

J S WIGGLESWORTH

Department of Paediatrics and Neonatal Medicine,
Hammersmith Hospital,
London W12 0HS

¹ Chamberlain, R, *et al*, in *British Births—1970*, vol 1. London, National Birthday Trust, Heinemann Medical, 1975.

² Wigglesworth, J S, and Husemeyer, R P, (1977). *British Journal of Obstetrics and Gynaecology*, 1975, 84, 684.

³ Pape, K E, and Wigglesworth, J S, in *Clinics in Developmental Medicine* Nos 69/70. London, SIMP with Heinemann Medical, 1979.

Overseas aid—urban hospitals or primary care?

SIR,—The British Government is to give £8.4m to help Tanzania to rebuild and equip a referral hospital to cover a population of 2m people (31 March, p 897). Yet as long ago as 1973 the Overseas Development Ministry was emphasising the importance of prevention and primary care in medical aid programmes: "In general, medical aid to developing countries is now devoted to rural health schemes and preventive health measures rather than to the construction of central hospitals."¹ Hospitals in cities and towns are accessible virtually only to people living in the immediate vicinity, and in many developing countries over 90% of the population live in rural areas. Urban hospitals are oriented towards curative medicine, and are expensive to run; the real health needs in countries like Tanzania are the prevention of the diseases which kill up to 20% of all children—malnutrition, measles, malaria, and gastroenteritis.

It is possible that such aid projects produce more harm than good for the recipient, because while the donor pays the capital costs the recipient nation has to pay the recurrent costs, so using resources which could be more appropriately used elsewhere. There are direct benefits, but mainly at the donor end: recurrent costs on equipment may pay back the capital costs of the donation after two to four years.

There may also be indirect benefits for the aid-giving country: by encouraging practice of curative hospital medicine the British aid programme is helping to develop a market for the medical equipment and drug industries in a way which supplying aid to primary care would be unlikely to do. Moreover, health workers in developing countries are encouraged to equate health care with hospitals; they are further alienated from the practice of appropriate health care, and instead apply for scholarships and jobs in Europe and America.

I disagree with Minerva, who finds the news of this grant welcome. The information suggests that, despite the Overseas Development Ministry's having recognised the health care needs of the developing world, the current financial crisis nevertheless requires that aid investment be put into something which will give a better return than would primary care.

JOHN YUDKIN

London N7 0AG

¹ Overseas Development Ministry, *Aid for Development Fact Sheet*, No 16 (revised edn). London, ODM, 1973.

Campylobacter colitis

SIR,—We agree with Mr M E Lambert and others (31 March, p 857) that campylobacter infection produces a proctocolitis as well as an enteritis. Their figures suggest that rectal biopsy is unhelpful. Only one out of their 11 cases showed specific changes, yet in our experience¹ biopsy is more useful.

In a series from the infectious diseases unit the appearances in all the eight cases biopsied were characteristic of infective colitis and clearly distinguishable from ulcerative colitis and Crohn's disease. This difference might be due to the timing of the biopsy in the history of the disease but could also reflect differences in histological interpretation. The authors state that the changes may be indistinguishable from those of "irritable bowel disease." We hope that this is a misprint.

ASHLEY B PRICE

J JEWKES

P J SANDERSON

Northwick Park Hospital
and Clinical Research Centre,
Harrow, Middx HA1 3UJ

¹ Jewkes, J, *et al*, *Gut* (abstract), in press.

* * * Yes, "irritable" was, regrettably, a misprint for "inflammatory"—a correction appears on p 1052.—ED, *BMJ*.

Vaccination and corticosteroid treatment

SIR,—Your expert, answering the question about smallpox and yellow fever vaccination in a patient on continuous corticosteroids (10 March, p 666), fails to take into account the reason for the steroid therapy. The questioner implies that the corticosteroids are being given as replacement (substitution) therapy in a patient with Addison's disease; as a result of this the patient should have physiological plasma levels of cortisol (or equivalent analogues). Under these circumstances the protective vaccinations carry theoretically no greater risk than in normal subjects, except that any reaction to the viral agent may constitute a stress and hence require tem-

porarily increased doses of corticosteroids, mimicking the normal physiological response. The situation is, of course, quite different when (as your expert implies) higher pharmacological in contrast to physiological doses of corticosteroids are being given for a variety of diseases. Under these circumstances I would agree that vaccinations are best avoided.

R I S BAYLISS

London NW1 4LJ

Hulka-Clemens clips

SIR,—Our first impressions of the case we reported (10 March, p 659) were similar to those of Mr N R A Trickey—namely, that the ectopic pregnancy present in the right fallopian tube was a result of an incomplete occlusion by the Hulka-Clemens clip on that tube. The clip on the left fallopian tube appeared to be correctly placed. We therefore only carried out a right salpingectomy. When the histological report returned with the finding that complete occlusion of the right fallopian tube was present, we felt it imperative to ensure that the left side was occluded.

When the hysterosalpingogram was performed the left tube was found to be patent. Laparotomy was therefore carried out and the clip was found to be incompletely occluding the lumen of the tube. The evidence that this pregnancy on the right side was due to transmigration of sperm is overwhelming. If Mr Trickey is still unhappy perhaps he would like to look at the sections himself.

G A CLARKE

A T LETCHWORTH

Royal Hampshire County Hospital,
Winchester, Hants

M C ANDERSON

Samarian Hospital for Women,
London NW1

World Medical Association

SIR,—I am, as president of the British Supporting Group of the World Medical Association, writing to you to express my deep concern that the Council of the British Medical Association is going to recommend to the Annual Representative Meeting that the BMA should withdraw from the World Medical Association. The points I am about to make are of course well known to the Council. I must nevertheless make them strongly because I feel that such withdrawal would not only create difficulties for the World Medical Association but would be highly damaging to the BMA in the field of world medicine—and indeed in the eyes of many of your members who value the international reputation of British medicine and the very splendid record that the BMA has had as a leader in promoting high standards of practice and ethics.

The BMA was in 1947 a founder member of the World Medical Association, an organisation that has always shown itself profoundly concerned with medical ethics throughout the world. It has had recent difficulties, but at a time when the American Medical Association is rejoining, the Eastern Block countries may become associated, and Canada and Scandinavia are expected to renew their membership it would indeed be unfortunate if the BMA should exclude itself.