transport season tickets. (6) Not providing staff with lease cars unless they need a car for work.

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1 Bhopal RS. One car down. *BMJ* 1992;304:451-2. (15 February.)

On your bikes

SIR,—To explore how to pursue the dual public health objectives of encouraging more cycling and promoting safer cycling¹ I undertook a survey of university students in Manchester in December 1989. I randomly selected 266 students from the 2110 residents of two halls and sent questionnaires. The only important difference between the hall residents and the total student population was that 70% of the hall residents were first year undergraduates compared with 36% of all students.

Completed questionnaires were returned by 208 students (78% response rate); 135 were cyclists, 56 of whom cycled in Manchester and 79 elsewhere. Seventy three said they never cycled. Those not cycling in Manchester (152) were asked to give reasons why not—up to three reasons per respondent. The commonest reason was that cycling in Manchester was too dangerous (104 respondents) and the second commonest that the chance of having a bike stolen was too high (93). Sixty one students indicated that cycling in Manchester would be “too unpleasant” (referring mainly to volume of traffic and fumes).

When asked to choose the most important ways to improve cycle safety from a list of suggestions 199 selected provision of cycle paths, 147 educating car and other drivers to drive more carefully with respect to cyclists, and 73 encouraging cyclists to wear helmets. One question asked: “If cycle helmets were made compulsory by law would you be more or less likely to cycle?” Seven students said they would be more likely to cycle, but 58 respondents (29%, 95% confidence interval 23% to 35%) said they would be less likely to do so. There was no significant difference between the cyclists and non-cyclists.

My results are consistent with the view that the perceived danger of cycling is one of the major deterrents to cycling. The respondents identified separate cycle lanes and changing driving habits as the most important ways of improving cycle safety. Helmets were generally perceived as being effective (results not reported here), but making them compulsory, as has been suggested,² would be another deterrent to cycling for around a quarter of students. Interestingly, the fear of having a bike stolen was also cited as an important deterrent. Public policy to encourage cycling should also aim at ensuring adequate provision of secure cycle parks, which are an important feature of some of the integrated public transport systems in Germany.³

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1 Godlee F. On your bikes. *BMJ* 1992;304:588-9. (7 March.)

2 *Accident prevention—a social responsibility*. London: Royal College of Surgeons of London, 1989.

3 Brunsing J. Public transport and cycling: experience of modal integration in West Germany. In: Trolley R, ed. *The greening of urban transport: planning for walking and cycling in Western cities*. London: Belhaven Press, 1990.

Doctors' contribution to environmental health

SIR,—If doctors are to contribute appreciably to environmental health it will have to be on the basis of inputs that cannot be made by the many other professionals, expert lay people, and agencies who have an interest in the environment.¹ Doctors' skill

lies in monitoring the environment and applying legislation. Our job is to identify and investigate effects on health, assess risks to health, improve the system of environmental control, and advance environmental policies to promote health. We also have a role in environmental education.

Medicine lacks a role in environmental health: Skill tends to be scarce and national, tied to long term activities, and lacking the flexibility and contacts to respond quickly to local problems. It is at a local, probably regional, level that developments are needed on four fronts.

Firstly, epidemiological skills (beyond the basic level provided by training in public health medicine) are needed so that medical advice is based on scientific argument. Rose pointed out “where dose response curves are considered to be linear or threshold-free, then it is the total emissions which need to be controlled, since many people exposed to a small risk may generate a large total of cases, albeit with no conspicuous risk to any one person or group. Yet much legislation is focused on protecting individuals from conspicuous and hazardous levels of exposure.”² Doctors should pursue this argument to its logical conclusion and challenge the attitude that current legal limits are unchangeable.

Secondly, information should be collated from the disparate published scientific papers, technical documents, and local and national reports and from the many multidisciplinary meetings on environmental issues, many of which charge admission at commercial rates.

Thirdly, a local infrastructure is needed to make use of whatever skill is available. The obvious person to coordinate activities is the director of public health, who has a unique platform for commenting and acting on environmental health issues, access to health information, and epidemiological and health promotion skills. Links are also needed with colleagues in occupational health. Public health medicine will, however, need to extricate itself from the task of wholly serving the management of the NHS and to set aside time for environmental health that is not continually raided by the demands of controlling communicable diseases.

Fourthly, where will resources come from? Do general managers in the health service see it as their business to finance “green offices” within departments of public health? Or should the polluter pay? To date, this principle has been applied only to environmental monitoring.

Delamothe's editorial should prompt a debate on these issues.¹

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1 Delamothe T. Airs, waters, places, and doctors. *BMJ* 1992;304:268-9. (1 February.)

2 Rose G. Environmental health: problems and prospects. *J R Coll Physicians Lond* 1991;25:48-52.

Changing to dry powder inhalation systems

SIR,—Susan Mayer and Andrew Haines's letter about ozone depletion and ultraviolet B radiation¹ prompts me to report my practice's experience with a changeover to dry powder inhalation systems.

About 18 months ago we almost instantaneously changed from using aerosols powered by chlorofluorocarbons to the Disk system, with Turbohalers and Spinhalers as back ups. Many patients commented on the increased benefit they received from the new devices, and roughly the same number bemoaned the loss of the simplicity of the aerosols. Our local pharmacist reports that he dispenses about two aerosols a month now, and the practice does not dispense any save to the occasional

temporary resident. As far as I know there is no ipratropium dry powder system yet, which is a small drawback. Our prescribing analysis and cost (PACT) figures for respiratory treatment are huge.

Such a change is easy to make: the customers either approve or acclimatise, and it might just be life saving—in the larger sense.

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1 Mayer S, Haines A. Airs, waters, places, and doctors. *BMJ* 1992;304:502. (22 February.)

Action Asthma: privatising the airways?

SIR,—In his letter Andrew Herxheimer alludes to a “national telephone asthma helpline,” and the mention of this in a letter about Action Asthma may lead to confusion. Though Allen and Hanburys does run a medical information service and may sometimes answer patients' inquiries, the most widely known asthma helpline is that run by the National Asthma Campaign. This is totally independent and staffed by four fully trained asthma nurses between 1 pm and 9 pm on Monday to Friday; it costs the price of a local call.

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1 Herxheimer A. Action Asthma: privatising the airways? *BMJ* 1992;304:505. (22 February.)

Medical arbitration

SIR,—We are involved in medical arbitration and in providing advice to medical arbitrators. Though a substantial number of arbitrations concerning medical issues take place, and frequently with a medical practitioner as arbitrator, there is no association or society of medical arbitrators. Further, the Chartered Institute of Arbitrators, which promotes arbitration generally, has no section devoted to medical arbitration.

If medical arbitration is to prosper—and we gather from recent announcements by the secretary of state for health that the government considers that it should—the training and appointment of medical arbitrators must be regularised. The most satisfactory method of achieving this would be to form an association of medical arbitrators, which could provide training programmes and maintain a panel of suitably qualified and experienced medical practitioners from which appointments could be made as required. Such an association could either affiliate itself to the Chartered Institute of Arbitrators or pursue its own course.

We would be interested to hear from medical practitioners, whether experienced in arbitration or merely interested in it, whether an association of the type we envisage should be set up. If sufficient interest is shown we intend to organise a meeting of those who have responded to discuss how matters might be moved forward. Any correspondence should be sent to Dr Douglas L Woolf.

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