We firmly believe that adoption of an "injury control" rather than "accident prevention" or, indeed, "crash" perspectives will allow a more appropriate focus by health authorities and health and safety strategists on the distribution of injuries and their socioenvironmental aspects.

CHRIS WORTH

West Yorkshire Health Authority,
Huddersfield HD4 5RH

GEOFF SPARKS

School of Human and Health Sciences,
University of Huddersfield,
Huddersfield HD1 3DH

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Sister hospitals in Bosnia

EDITOR,—Hugh Dudley is more than right in his straightforward statements that "putting a team in place is far more effective than evacuating people . . . the very presence of a team has great meaning for the community" and "surgical teams will never change the course of history but will . . . be remembered in the marketplace."¹

More than remembered—in our case, such help may mean life for hundreds of people and, indirectly, a psychological impact that would facilitate the flow of humanitarian convoys to all endangered peoples in Bosnia and Herzegovina.

Nova Bila Hospital, located near Novi Travnik, middle Bosnia, is the only hospital in an enclave with a surrounded Croatian population of 70 000. Since the hospital was established in the spring of 1993 its staff have performed 330 operations with general anaesthesia and 1500 with local anaesthesia; 59 have been on wounded children. Some 7000 sick civilians were treated in the hospital, with 50 babies born every month, 70–80 patients being checked daily, and about 60 visiting the pharmacy looking for medicines.

The hospital has serious problems with staff, supplies, equipment, and communication. Raging war and total lack of mutual confidence of warring sides cut the hospital completely off from the world, from all those who could help. It urgently needs a paediatrician, gynaecologist, neurologist, psychiatrist, internist, anaesthesiologists, and all other specialists. Haemodialysis machines, electrocardiographs, and equipment for developing x ray films are among the most needed devices. All drugs are in short supply.

We have already sent a similar appeal for help to our colleagues in Croatia. I believe, however, that because of the delicacy of our setting, foreign doctors and help would be more efficacious and have wider impact. The presence of foreign doctors would assure all sides of their impartiality and this, in turn, would ease the flow of supplies, diminish the direct danger to the hospital, and facilitate the evacuation of heavily wounded patients. Thus, purely medical aid and presence may have far reaching consequences that might prove Hugh Dudley wrong in at least one of his statements: surgical help may, at least a little, also change the course of history.

Knowing the situation in Nova Bila, the doctors of Mostar Hospital proclaimed Nova Bila Hospital as a sister hospital. The idea of establishing the sister hospital relation stems from a recent initiative of the International Physicians for the Prevention of Nuclear War (IPPNW) to formalise the concept of IPPNW peace hospitals as places for "inner and outer peace."² The idea includes the concept of proclaiming hospitals endangered by war as sister hospitals of those willing to help.³ In as much as Mostar Hospital employs physicians from all major nationalities of Bosnia and Herzegovina (Moslems, Croats, Serbs, and Jews) and

impartially treats patients of all nationalities, occupations, and sides, we have submitted our application for an IPPNW peace hospital. Unfortunately, the war proved faster than the acceptance procedure and we decided to work along the lines of a peace hospital even before the formal decision of the IPPNW. Both hospitals would appreciate help from our foreign colleagues to find our sisters in more peaceful and less troubled parts of the world.

ANTE KVESIC

Hospital "Bijeli Brijeg,"
Mostar,
Bosnia and Herzegovina

IVAN SARAC

Civilian Health Service,
Croatian Republic of Herzeg-Bosnia,
Bosnia and Herzegovina

SLOBODAN LANG

IPPNW Working Group on Peace Hospital/Health Centers

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Value of confidential inquiries

EDITOR,—In saying that the confidential inquiries into maternal death are of doubtful value Jane Wells and Jean Chapple ignore their educational impact.¹ Those of us who worked in obstetrics in the three decades after 1950 always eagerly awaited the confidential inquiries. They certainly increased our knowledge of where the thrust of education for undergraduates and postgraduates should be. Teachers' attitudes to the problems to be solved changed: emphasis was placed on the organisation of the midwifery services; the importance of management in "toxaemias," haemorrhages, abortions, and sepsis; and the dangers of anaesthesia and pulmonary embolism. Thus the inquiries formed a basis for more relevant teaching at all levels. Opinion on what was important to look out for, in all phases of childbearing, was undoubtedly altered. It may not be possible to measure in statistical terms the effects of these changes, but they did occur.

PHILIP RHODES

Wakerley,
Oakham,
Leicestershire LE15 8PA

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Unemployment and psychiatric admissions

EDITOR,—Robert M Kammerling and Susan O'Connor's study of the relation between socio-economic status and psychiatric admission rates is useful.¹ Their finding that the unemployment rate outperformed the Jarman score as an indicator of admission rates agrees with findings in Sheffield.²

Their conclusion that the allocation of resources to fundholders in general practice should take account of deprivation as reflected by unemployment rates requires comment. They acknowledge that differences in clinical management can affect use of acute beds—perhaps particularly reflected in variations in length of stay and ratios of readmissions to admissions. In districts there is a weak negative association between the proportion of psychiatric nurses working in the community and admission rates.³ Activity of mental health services is represented by more than inpatient admissions, and currently the general practice

fundholding scheme includes only community mental health services. In a study of referral patterns over one year in south east Sheffield we found wide variations in general practitioners' referral rates for inpatient admission, for consultant domiciliary visits, for outpatient assessment, and to community psychiatric nurses and no clear correlation with deprivation, which almost certainly mainly reflected the practice of individual general practitioners. These findings suggest that caution is required in allocating resources on the basis of activity alone, but there is little evidence to suggest that unemployment rates should be taken as a proxy of need for community mental health services as opposed to need for inpatient admission.

The introduction of fundholding may shift the basis of community mental health services from secondary to primary care. More work is needed to establish a rational basis for allocating resources for mental health care. Kammerling and O'Connor's paper perhaps indicates that research should attempt to establish correlations for community mental health activity rather than relying on a remarkably high and consistent association between unemployment and admission rates to dominate thinking about funding.

D B DOUBLE

R HUWS

South East Sheffield Mental Health Services,
Sheffield S12 4QN

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Height and weight of rural and urban children

EDITOR,—Richard Reading and colleagues report that low birth weight and children's heights differ considerably between urban and rural areas in Northumberland, even after social deprivation was taken into account.¹ For both indicators rural areas produce better outcomes.

It is surprising that nutrition is not mentioned in the study, let alone considered as a possible cause of these important differences, given the worldwide evidence of the links between poor nutrition, low birth weight, and reduced growth. Among the many studies by Margaret and Arthur Wynn of dietary influences on health, growth, and handicap, one in particular points to major differences between rural and urban areas in the percentage of home grown goods.² The nutritional quality of freshly grown produce is generally recognised to be superior to that of food harvested before it is fully ripe, transported long distances, packed, and left on shop counters for sale many days later.

Other studies of women's nutritional intake, by the same authors, include an examination of the links between hypertension, low birth weight, and deficiencies of magnesium and other nutrients³; they have also studied the impact of maternal nutrition around the time of conception, again linking this to birth outcomes.⁴ These studies themselves cite a considerable volume of other research evidence linking nutrition and low birth weight in Western countries. The idea that malnutrition is not a serious problem in the United Kingdom (an idea held at one time by the former Department of Health and Social Security) is no longer tenable.

It is interesting to note that magnesium is one of the key nutrients in serious deficiency as a result of food processing.³ Again one comes back to the strong implication that the individual nutrient quality of rural diets, with their high proportion of home grown produce, is likely to be superior to