The changes in the armed forces medical services merely reflect the changing role of the armed forces themselves and the operational scenarios for which medical support might be required in the future. The fact that the core hospital at Haslar will be for all three services and enlarged in terms of both the number of beds and the range of specialties represented will enable us to provide an even greater range of postgraduate training than at present. The introduction of the military units in large district general hospitals will again allow greater training opportunities than we have previously been able to provide in our small service hospitals. I can therefore confidently state that training opportunities for the doctors who remain will be enhanced and their service career patterns will not be affected. Uniformed patients will be referred, as at present, to uniformed consultants, either at the core hospital at Haslar or, if it is more convenient, to the nearest military-civilian unit, and they will receive the same treatment as they presently enjoy.

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1 Beecham L. Reductions in defence medical services causes BMA concern. *BMJ* 1995;310:196. (21 January.)

Life expectancy in children with cerebral palsy

EDITOR,—In their paper on life expectancy in children with cerebral palsy¹ Jane L Hutton and colleagues remark on our findings in two selected studies,^{2,3} stating that our subjects with developmental disability seemed to have a much shorter life expectancy than they found. We studied people who had devastating learning disabilities as well as people with less severe disabilities. Some groups had a very poor prognosis—that is, those who were immobile, could not roll over, were tube fed, had no use of their arms or hands, etc. In one of these groups who could roll over, however, estimated survival was similar to that in Hutton and colleagues' group who required a wheelchair.

We did not use the wheelchair item in our papers because it did not discriminate between the degrees of immobility. Hutton and colleagues chose to ignore differences in the severity of disabilities, including levels of mobility and types of feeding, when they discussed the differences between our findings and theirs.

To prove our point we adopted their cruder definitions of mobility—that is, wheelchair required and help needed for propulsion—and a separate category for manual dexterity, defined as inability to feed and dress without help, as well as their years of birth and degree of learning disability (all had cerebral palsy). We used all ages of admission to the California system. We estimated survival over 11 years for 3792 people meeting the wheelchair criteria. The five and 10 year cumulative proportions surviving were almost identical with those in Hutton and colleagues' study. When we used the criterion "does not feed or dress self without help" our cumulative proportions surviving after five and after 10 more years were also similar to those of Hutton and colleagues. We also used period life tables for Hutton and colleagues' definitions of mobility and manual dexterity. We selected subjects who received services during 1987-90 and estimated their average remaining lifetime. The results again were similar to the median survival estimated by Hutton and colleagues. These findings merely confirm that the definitions used by Hutton and colleagues did not have the precision necessary to replicate our findings on who would and would not have a reasonable survival outcome.

Diagnoses such as cerebral palsy and learning

disabilities are not determinative predictors in as much as most subjects with these diagnoses are not substantially disabled. The category "patients confined to wheelchairs" is too broad to be a definitive predictor.⁴

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- 1 Hutton JL, Cooke T, Pharoah PO. Life expectancy in children with cerebral palsy. *BMJ* 1994;309:431-5. (13 August.)
- 2 Eyman RK, Grossman HJ, Chaney RH, Call TL. The life expectancy of profoundly handicapped people with mental retardation. *N Engl J Med* 1990;323:584-9.
- 3 Eyman RK, Grossman HJ, Chaney RH, Call TL. Survival of profoundly disabled people with severe mental retardation. *Am J Dis Child* 1993;147:329-36.
- 4 Eyman RK, Borthwick-Duffy SA, Call TL, White JF. Prediction of mortality in community and institutional settings. *Journal of Mental Deficiency Research* 1988;32:203-13.

Drivers with sleep apnoea

EDITOR,—Ashley Woodcock and Patricia Stone pose the major moral dilemma of how to manage patients with sleep apnoea who hold licences to drive public service or heavy goods vehicles and are reluctant to declare their illness to the Driver and Vehicle Licensing Agency.¹ They mention the temptation to blackmail such patients into treatment with threats of driving bans. The issue here is not the treatment but the ban. The Driver and Vehicle Licensing Agency recommends that people who hold licences to drive public service or heavy goods vehicles should stop driving if they have sleep apnoea. The patient therefore has an obligation to inform the agency about the condition, which is well known to cause accidents, as Woodcock and Stone point out.

Surely there is no moral dilemma here. Doctors' primary responsibility is to the public at large, not to a person who might cause death or disability to other people. The situation is exactly the same in epilepsy. The recommended practice is to inform patients of their statutory responsibility to tell the Driver and Vehicle Licensing Agency about their condition, to write this in the notes, and if necessary to confirm it with a letter to the patients sent by registered post. The patients' response can be checked by asking them, but also by an inquiry to the agency, at which stage the doctor does not need to provide any clinical information. If patients do not report their condition, however, the doctor should send them a letter telling them that he or she is obliged to inform the licensing authority about their condition and recommending that they should consult a solicitor about the issue.

This sounds legalistic, but the communications can be made in a friendly manner, emphasising encouragement rather than threat and expressing regret at the need to take the ultimate action.

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- 1 Woodcock A, Stone P. Should obesity be treated? *BMJ* 1994; 309:1442. (26 November.)

Driving, glaucoma, and the law

EDITOR,—Contrary to the impression given by T Potamitis and colleagues,¹ glaucoma in a single eye need not be notified to the Driver and Vehicle Licensing Agency. The condition can be regarded as a prospective disability and therefore notifiable as soon as field loss in both eyes occurs. It is the patient's responsibility to notify the agency, but the doctor needs to remind the patient of his or her obligations.

The minimum visual field for safe driving is a field of vision of at least 120° on the horizontal measured by a Goldmann perimeter with the III4e settings (or equivalent perimetry). In addition, there should be no appreciable field defect in the binocular field that encroaches within 20° of fixation either above or below the horizontal meridian. By this means homonymous or bitemporal defects that come close to fixation, whether hemianopic or quadrantanopic, are not accepted as safe for driving. Isolated scotomas represented in the binocular field near to the central fixation area may also be inconsistent with safe driving.² Only if the minimum visual field for safe driving cannot be achieved will the driving licence be revoked.

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- 1 Potamitis T, Aggarwal RK, Tisoulamas M, Rene C, McLaughlin J, O'Neill E. Driving, glaucoma, and the law. *BMJ* 1994;309: 1057-8. (22 October.)
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Making routine data adequate to support clinical audit

"Routine" is inadequately defined

EDITOR,—In their editorial on the need for adequate routine data to support clinical audit Martin McKee and colleagues fall into their own trap.¹ They claim that unambiguous definitions are needed, yet use ambiguous words in their title. Our interpretation of "routine data" is data collected as byproducts of clinical care by the clinician and as an integral part of the process of care. Their definition is that the data are managerial data collected through processes outwith the clinician's control. On the basis of their definition it is not surprising that the data are incomplete and invalid. We have shown that data collected as byproducts of clinical care are valid and able to inform education and service planning, with resultant improvement in the service provided.^{2,3}

It is not surprising that routine data as McKee and colleagues understand the term are inadequate to support audit and contracting. The way ahead for the health service must be to establish a culture in which accurate, structured data collection is an integral part of the process of care, as much second nature to clinicians as it has been to write unstructured notes in the clinical record in the past. When that culture is achieved clinicians will own their own data and trust the information that emerges. Then it will be of use not only for clinical audit but also for activity analysis, service planning, management of resources, and research.

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- 1 McKee M, Dixon J, Chenet L. Making routine data adequate to support clinical audit. *BMJ* 1994;309:1246-7. (12 November.)
- 2 Williams JG, Greenway SC, Morgan JM, Cheung WY. *Report of*