Results

In the first three months of the definitive screening scheme 442 children have been examined—86% of the children sent for, the rate varying from 59% to 100%. The tests have taken 37 orthoptic sessions.

Thirty-seven of the 442 children have been referred to a hospital ophthalmic clinic with a suspected abnormality, and in only one case was the abnormality not confirmed (table I). Thirty-two other children had abnormalities, which had been picked up by their family doctor or child welfare clinic. This means that the traditional procedures had picked up less than half of the abnormalities in this group of children. As a result of our screening 10 children had spectacles prescribed for defective visual acuity, nine for latent squint, and one for manifest squint (table II).

Comment

The orthoptists are happy with the work load, which is shared among all the members of their department; and the administration is working smoothly. There is a most encouraging response from the parents, who, though they are mostly unaware of the problems of visual function in children, are invariably glad that their children's vision is being examined at such an early age. In two years these children will have their routine school eye test, and we shall be interested to discover whether the primary visual screening has reduced the incidence of persistent amblyopia and related abnormalities.

TABLE I—Incidence of defects in children having primary visual screening

	No (%) of children
Total examined	442
Referred to hospital clinic	37 (8)
Defect not confirmed	1
Defect already diagnosed	32 (7)
Total defects	68 (15)

TABLE II—Nature of defects found in primary visual screening

	No of children with:		
	Manifest squint	Latent squint	Defective visual acuity
Glasses ordered	1	9	10
Glasses not necessary	4	4	
Glasses not yet advised	1	3	4
Total	6	16	14

We wish to thank Mrs Barbara Roy for her help with the feasibility studies.

Reference

¹ Roy, B, et al, *British Orthoptic Journal*, 1977, **34**, 23.

How to do it

Take an examination viva

N K SHINTON

British Medical Journal, 1978, **2**, 1694-1695

The relative importance of the viva voce section of an examination varies from one examination to another. It may be the final assessment of the candidates and therefore only important to those with borderline results, or it may carry a proportion of marks. In some examinations it may be the method of deciding on distinction or honours. These are matters of immediate concern more to the examiner than to yourself and you should approach all viva voce examinations with the intention of conveying to the examiner the fullest possible extent of your understanding of the subject to be discussed. The candidate's approach may be vital for success. Candidates' personalities vary from the overconfident aggressive ones to the shy timid people who find this part of the examination the greatest ordeal. Personality differences cannot be completely overcome and it is better for you to behave normally and not attempt to act out a part which, to your embarrassment, will probably be detected. A determined effort to be composed is always worth while but,

in furtherance of this aim, I wouldn't recommend tranquillisers, and hypnotics the night before can leave you overcome by sleep at a critical moment.

The moment of face-to-face contact between the examiner and yourself is important as first impressions can make a difference. For this reason, if you are neatly dressed you have an advantage over someone who is slovenly or flamboyant. Likewise, your entrance into the room and the way you take the proffered chair may convey an impression of alertness or sloth.

The initial question is usually a general one to give you time to settle down and to allow a rapport to develop. At this stage it is most important for you not to repeat the question while you think out the answer—this is a most irritating habit, and remember that the examiner will be listening to numerous candidates. It is better for you to start talking about the subject and if possible go on until the examiner either indicates that he is satisfied or moves on to another question. In the unfortunate event that you do not understand the question, ask for it to be repeated, or say that you don't understand. If you really don't know anything about the subject then say so, because this fact will eventually be deduced and valuable time will have been lost. You should appreciate that in the time allotted you must get across the maximum extent of your knowledge. Many candidates know the subject but are unable to communicate their knowledge to others.

Testing your ability to communicate is the whole purpose of a viva voce examination. Always avoid vagueness or using words

to take up time—no credit will accrue from this. Not infrequently the examiner hands across the table a specimen, photograph, or data for comment. It is a good principle to describe the exhibit and then, if possible, what it represents. At the end of the interview always leave graciously, however disagreeable it may have been, as this leaves a good impression and in borderline circumstances may be influential.

A last word about distinction vivas. These are a battle of wits and knowledge between an above-average examinee and the

examiner. The questions are certain to stretch the candidate's knowledge to the utmost but for that reason may be quite enjoyable for both. The process of determining the extent of your knowledge may be long or short, so the length of time taken on the procedure is of little importance.

Eventually this series will be collected into a book and hence no reprints will be available from the authors.

A Modern Epidemic

Road accidents—seat belts and the safe car

BY A SPECIAL CORRESPONDENT

British Medical Journal, 1978, 2, 1695-1698

One evening last spring a girl and her father set off in the car to buy fish and chips—an unambitious drive, but they pulled up sharply to avoid a dog. Although they were doing only about 15 mph (24 kph), the child's head went through the windscreen because she was not wearing a seat belt. She received serious lacerations on her face. The London casualty department she attended had seen three cases in the previous year where the victim had lost one or both eyes in similar circumstances.

Seat belts

Seat belts often seem unnecessary while driving slowly, especially for short journeys in towns. But well over half of all car injuries occur in accidents in built-up areas,¹ and there are no safe speeds. Yet publicity campaigns have been least successful over town driving, when only about a quarter of the front-seat occupants wear seat belts. Without legislation the proportion of wearers cannot be expected to rise far beyond this. Even last April, just after a publicity campaign, there were only a few per cent more wearers—32.4% in the country as a whole for drivers and 35.4% for front-seat passengers, with 47% for drivers on motorways (women and the 25-44 year age group have better than average rates).² But some, though not all, of the 23 countries with legislation have achieved wearing rates of 80-90%, or even more.³

The last Bill to make seat-belt wearing compulsory in the whole of Britain (the third to be introduced) was narrowly defeated in the House of Lords on 26 April 1977 after an often emotional debate.⁴ Argument was waged on the acceptability of seat belts, problems of enforcement, and—most prominently—the issue of compulsion versus personal freedom. One speaker went so far as to say, "Away with statistics," and many banded about sentiments such as "Liberty is more important than life." The main crux, however, was the belief that seat belts could be the cause of injury and even death (a commonly held view)—and therefore people should not be compelled to use them but should be free to make up their own minds. A recent survey showed drivers to be 3:2 against compulsion, though 90% thought that seat belts were effective.⁵ The facts must be given

the widest publicity to change the climate of opinion if the next Bill, which the Government has now promised, is to fare better than its predecessors.

Meanwhile with every year that passes some 600 people die and over 11 000 receive serious injury unnecessarily; this minimum estimate, based on the 1977 casualty figures, assumes a 90% belt-wearing rate, with a net decrease in deaths of 24% and in serious injuries of 36%.³ Many surveys probably underestimate the effectiveness of seat belts, since some of those who escape injury altogether are not included in the calculations. On the other hand, people who have accidents, especially if they have high blood alcohol concentrations, and those driving at night are least likely to be wearing belts.^{6 7}

Car seat belts were first suggested by C L Straith in the United States in the 1930s, and the effects of the various devices are by now massively documented. They are primarily designed to prevent injuries resulting from frontal collisions, which cause 60% or more of all injuries⁸—more if near-frontal impacts are included. On impact the car comes to a standstill in perhaps a tenth of a second, but an unbelted occupant continues to move forward at about the previous speed of the car until he is abruptly stopped by the windscreen or other part of the car—or, worse, is ejected from it. The belted occupant is saved from ejection and can also decelerate more gradually; thus his body is subjected to much lower and more evenly distributed forces. In practice, because it holds the occupant in his seat, the safety belt may be valuable also in other types of accidents, including overturning.

CAN SEAT BELTS BE A DISADVANTAGE?

Belted occupants are rarely killed except in higher-speed accidents; a given severity of injury needs an average speed 12 mph (19 kph) greater if the occupant is belted than if he is unbelted.⁶ For some accidents, however, seat belts might be less effective, particularly for certain side impacts and some of the severest crashes when the passenger compartment is crushed. But do they sometimes make things worse?

Fears of being trapped in a burning car are often mentioned, but fire occurs in less than 0.5% of accidents, mostly very severe ones in which the victims are more likely to be alive and conscious and to escape before the fire starts if they are wearing