CORRESPONDENCE

Correspondents are urged to write briefly so that readers may be offered as wide a selection of letters as possible. So many are being received that the omission of some is inevitable. Letters should be signed personally by all their authors.

Occupational Health

SIR,—In your leading article "E.M.A.S. Gets Going" (23 August, p. 449) you ask whether occupational health is a specialty in the sense that cardiology, neurology, and surgery are. Two of these specialties are based on anatomical systems and one on a technique. Occupational health is based on two techniques: (1) the taking of an occupational history, both present and past, and making a diagnosis and giving advice in the light of this; and (2) the scientific assessment of the working environment and its correction if necessary by the techniques of occupational hygiene. You ask, moreover, what is the scope of occupational health? This is to apply medicine at the interface between a man and his work or, put more simply, to study the reciprocal relation between job and health. We must be a little on our guard against the conservatism of our profession, which tends to greet any innovation by saying either that there is no such thing or alternatively that we have been doing it all the time.

It is, of course, not unknown for governments to spend money in the medical field for what look like political reasons, but it is surely a little unlikely that the Treasury would sanction the Employment Medical Advisory Service budget if there was really nothing to do. Moreover, in the same issue as your article are advertisements from three industries for occupational health doctors at salaries within the consultant range. Now, industry earns the money it spends and its attitude is different from (and possibly a bit more responsible than) publicly funded organizations such as the N.H.S. or the universities. On the whole industry does not spend money on things which it does not consider worth while. By the same token the clinical and hygiene service, the North of England Industrial Health Service, attached to our Newcastle department, is earning about £80 000 p.a. from industry.

Whatever the doubts of our more conservative colleagues, there seems to be something here which the hard-headed feel is worth paying for.—I am, etc.,

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Myocardial Infarction and H.G.V. Drivers

SIR,—In your leading article on "Rehabilitation after Acute Myocardial Infarction" (16 August, p. 394) you question the recommendation of the Joint Working Party of the Royal College of Physicians and the British Cardiac Society that heavy goods vehicle (H.G.V.) drivers are among "several occupations not open to those who have had myocardial infarction, because of the risk to the public.[1] The following points seem pertinent:

(1) H.G.V.s are vehicles designed to carry goods which are more than three tons (3·05 tonnes) unladen weight or are articulated vehicles. They are therefore not light vans or light delivery vehicles.[2]

(2) H.G.V. drivers are professional drivers who often spend most of their working day at the wheel. The longer any driver is at the wheel, the greater must be the risk that acute illness, though generally regarded as a rare event, will occur while driving. H.G.V. drivers often work on schedules and find it difficult to stop driving if they feel unwell. H.G.V. drivers tend to drive on trunk routes where they are surrounded by more people and vehicles to collide with if they do lose control. The greater the mass of the vehicle, the more damage it does to other vehicles or people in a collision. The load carried can also be important; a tanker of 100-octane petrol is potentially very hazardous.[3]

(3) Weinblatt *et al.*[4] reported in a study of 55 000 men of all occupations (insured under the Health Insurance Plan of Greater New York) that men under 55 had 9·1 times the risk of a first recurring myocardial infarction compared with the risk for a first myocardial infarction in the same population. Peterson and Petty[5] reported that three-quarters of 81 sudden deaths at the wheel were due to ischaemic heart disease.

(4) Car occupants are more likely to be killed or seriously injured in a collision with an H.G.V. than in a collision with another car. Gissane and Bull[6] reported that of 564 deaths of car occupants, 40% were from collisions with lorries, in spite of the fact that lorries are outnumbered by cars by 7:1.

(5) There is no means of ensuring that the holder of an H.G.V. licence will stick to a particular type of vehicle. H.G.V. drivers tend to move jobs fairly frequently, and, though a good employer would limit a driver rehabilitated from an acute ischaemic episode to certain types of vehicle or certain hours of driving, there is no means of ensuring that the driver would stay with that employer and not move to an unsuitable job. The trained H.G.V. driver who can no longer drive an H.G.V. as defined still has the choice of driving light vans.

Public safety considerations of this kind give strong support to the working party in including H.G.V. drivers among "occupations having to do with public safety such as heavy goods vehicle driver, passenger service vehicle driver, airline pilot and all holding flying licences, and air traffic control officer." The Medical Commission on

Accident Prevention also recommends that drivers who have had a myocardial infarction should not hold an H.G.V. licence.[7]—I am, etc.,

ANDREW RAFFLE
Chairman of Transport Committee, Medical Commission on Accident Prevention

London N.W.1

1 Joint Working Party, *Journal of the Royal College of Physicians*, 1975, **9**, 281.
2 Road Traffic Act 1972.
3 Raffle, P. A. B., *Transactions of the Medical Society of London*, 1974, **90**, 197.
4 Weinblatt, E., *et al.*, *American Journal of Public Health*, 1968, **58**, 1329.
5 Peterson, B. J., and Petty, C. S., *Journal of Forensic Science*, 1962, **7**, 274.
6 Gissane, W., and Bull, J., *British Medical Journal*, 1973, **1**, 67.
7 Medical Commission on Accident Prevention, *Medical Aspects of Fitness to Drive*, 2nd edn. (revised). London, M.C.A.P., 1974.

Prevention of Tetanus in the Wounded

SIR,—It was with some dismay that I read the paper by Dr. J. W. G. Smith and others (23 August, p. 453) advocating a wider use of human immunoglobulin in the prevention of tetanus. I fear that their views, if widely propagated, will lead to a vast and unnecessary increase in the use of human immunoglobulin and that we shall revert to its use for protection against medicolegal proceedings rather than the protection of the patient.

Though they emphasized that their views are to be taken only as guide lines, there are a vast number of people whose immunity status is unknown, who have not had a complete course of toxoid, or whose last booster was over 10 years ago. Similarly, there are a large number of wounds which are over six hours old when they reach the theatre, which cannot be adjudged wholly "clean," and which have more than "negligible tissue damage."

In an accident and emergency unit dealing with over 50 000 new patients a year, of whom 70% have suffered trauma, no patient with tetanus has been seen since the unit opened seven years ago. Adsorbed tetanus toxoid, either initiating a course or as a booster where necessary, is used routinely, combined with adequate surgical treatment of the wound. Antibiotics are used only for badly contaminated lacerations. This, to my mind, is the rational approach to tetanus in our society rather than endeavouring on rather vague premises to give better protection to the one in over 100 000 lacerations likely to be at risk.

AUSTIN BROWN

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Training for Overseas Graduates

SIR,—Drs. B. Senewiratne and M. Kanagarajah in their article on postgraduate training in a developing country (26 July, p. 213) stress that if Britain and other developed countries are to make a real contribution to medicine in developing countries they should accept some doctors for training with the emphasis on work rather than passing examinations.

In 1972 I had the good fortune to work for three months in Ceylon, teaching undergraduate and postgraduate students. Since that time I have had a succession of Ceylon graduates who have come to work in this unit for a month at a time before going on to work in other parts of the country. As a result of this experience I wrote to the British Council saying that it seemed to me that one answer to the problem of training overseas postgraduates would be to establish specific training posts. For example, in this unit we have a fairly comprehensive training programme in neurology, but the posts are filled by direct competition and this makes it very difficult for overseas graduates. I suggested a fellowship which would be filled only by graduates who had been specially selected by their own country's doctors with a view to returning to a consultant post. The British Council were interested and sent this proposal on to the Overseas Development Administration, from which nothing further has been heard.

There must be many hospitals in this country where a training fellowship of the type visualized by Drs. Senewiratne and Kanagarajah could easily be established. If some relatively independent body such as the British Council or the British Postgraduate Medical Federation were to set up a register of such posts and send lists of these posts to medical schools in developing countries, then at least some of the problems raised by Drs. Senewiratne and Kanagarajah would be answered. It should be a simple matter to meet the cost of these training fellowships (which would simply be a registrar's salary) from money such as the Commonwealth educational co-operation funds of the British Council or some similar source. I would also suggest that once these travelling fellowships had been established an exchange scheme at registrar, senior registrar, and consultant level could be contemplated.

If anyone, in Britain or abroad, interested in setting up such a register would write to me I will undertake to present the information to the British Council and the British Postgraduate Medical Federation and to try to get such a register established on a formal basis.—I am, etc.,

L. S. ILLIS

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Who Cares For Head Injuries?

SIR,—The neurosurgeon is the person best qualified to be responsible for the treatment of patients with head injuries (Professor Bryan Jennett, 2 August, p. 267). Their treatment should be carried out within the accident service, where such an organization exists. This is important in part because more than one-third of these patients with serious head injury have other injuries that require simultaneous treatment. The efficient treatment of this type of patient requires a well-organized team, and the neurosurgeon should also play an important part in deciding when other necessary procedures can be carried out. A small proportion of patients with head injury will need craniotomy. The quality of the decision as to when it is necessary is at least as important as the technical skill in carrying it out, and the neurosurgeon is best qualified to make this decision.

This was the view of the late Professor Sir Hugh Cairns. It was put into effect when the accident service was started in Oxford in 1942 and the policy has since been continued by a series of distinguished neurosurgeons. One graphic result of this policy was the reduction of the mortality rate from 9% in the first 1000 cases to just over 3% in the fourth. Though the 3% figure was achieved in Oxford about 20 years ago, I believe it is still well below the national average.—I am, etc.,

JAMES C. SCOTT

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SI Units

SIR,—We write to protest at the general introduction of SI units into medicine without adequate consultation with those who have to interpret laboratory reports in the clinical situation.

In our experience this has already led to waste of time and effort, confusion, and danger; and even when we have got used to the units, which involves effort that would be more usefully employed in learning things of real relevance to patient care, the units are in many more instances inappropriate for the range of quantities met with in clinical medicine. It is noticeable when one visits the Continent how at producer and consumer level the old measures of weight etc. are still used instead of the metric system because they represent natural quantities rather than artificial concepts; for instance, a yard as the length of a step is easier to gauge than a fraction of a wrong measure of the circumference of the earth; and the same applies to many measurements used in clinical medicine. We have a particularly difficult task in paediatrics because there are different standards for children of different ages, size, and sex to which we have got used and only pathologists with paediatric experience understand.

There seems to be a kind of general law that when a committee recommends something foolish—like Salmon or Seebohm—its recommendations are immediately put into effect to the detriment of the Service; whereas when it recommends something sensible—like Briggs—it is shelved.

When the tide is artificially induced there is something to be said for Canute trying to put it in reverse in the interest of efficiency, safety, and common sense.—We are, etc.,

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V. MILLER

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Ischaemic Heart Disease, Vitamins D and A, and Magnesium

SIR,—Professor V. Lindén (14 September 1974, p. 647) has suggested that vitamin A, by protecting against the hypercholesterolaemic effect of vitamin D, may influence the incidence of myocardial infarction. His epidemiological study (in Norway) related to relatively high vitamin D intakes. Vitamin A also protects against the osteolysis and renal and arterial calcinosis of experimental hypervitaminosis D.[1] The risk of hypervitaminosis D in the United States, where the greatest source is fortified milk, may be even greater than in northern Norway, where most of the vitamin D derives from fish liver, which is rich in vitamin A.