

skeletal dysplasias because there is no appreciable shortening of the limbs in early fetal life. (The mucopolysaccharide enzyme disorders are an exception in that they can be diagnosed biochemically.) Severe achondroplasia, for example, can be diagnosed by weeks 20-22 of pregnancy but not any earlier, and the milder form cannot be detected antenatally at all.

A positive approach to clinical management can achieve much to help these patients. Patterns of inheritance can be identified and genetic advice given. Advances in orthopaedic surgery have opened up possibilities of correcting deformities such as limb malalignment and spinal curvature, as well as leg lengthening and replacement of joints, that would not have been considered 20 years ago. In addition, this group of disorders provides a fascinating and fruitful topic for both prenatal and postnatal research.

These patients deserve more recognition, help, encouragement, and skills than are offered in many parts of the country, and the Skeletal Dysplasia Group for Teaching and Research was formed in 1979 with the aim of speeding up progress. It has already attracted over 100 members, including orthopaedic surgeons, radiologists, paediatricians, medical geneticists, histopathologists, and biochemists. Its activities are funded partly by the annual membership fee of £10 and partly by donations from individuals and organisations: the society is now a registered charity. Funds also come from royalties for the recently published *Atlas of Skeletal Dysplasias*.<sup>2</sup> Membership is open to any medically or scientifically qualified individual, and further information is available from Mr M A Smith, Orthopaedic Department, St Thomas's Hospital, London SE1 7EH.

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1 Wynne-Davies R, Gormley J. The prevalence of skeletal dysplasias. *J Bone Joint Surg [Br]* 1985;67:133-7.

2 Wynne-Davies R, Hall CMH, Apley AH. *Atlas of skeletal dysplasias*. Edinburgh: Churchill Livingstone, 1985.

## Twelve dead and a complacent report

In the past fortnight 12 people have died and 19 been seriously injured in two much publicised crashes on British motorways. Both accidents were the result of human error, and yet the refusal to deal adequately with the direct approach to influencing human error is one of the worst failings of a recently published government report on road safety.<sup>1</sup> The report is the result of the first full review within government for more than 10 years of British road safety and has proved a disappointment. The interdepartmental working group that took three years to produce the report talks of the importance of gaining an "accurate understanding of the nature of the road casualty problem" and then limply concludes that "for the majority of road safety functions we simply do not know what returns are being achieved in terms of casualties and moreover have little prospect of finding out."

The World Health Organisation has long argued that an epidemiological approach is needed to road traffic accidents,<sup>2</sup>

yet those responsible for road safety in Britain have never heeded this advice. The first step should be to examine the quality of the data that we do have on road traffic accidents, and we know that about a third of injuries seen by hospital doctors do not appear in police returns<sup>3,5</sup> and that the correlation between the opinions of the police and doctors on the severity of the injuries is not good.<sup>5</sup> That is why we need record linkage, which is feasible<sup>6</sup> and produces valuable data.<sup>7</sup> The report fails even to mention these important attempts to improve the basic data.

Human error is the prime factor in 70% of accidents and a contributory factor in all but 5%. The working group claims that much human error can be reduced only indirectly by creating safer vehicles and a safer environment, but we may well be approaching saturation point in the cost effectiveness of such modifications. Direct measures to influence human behaviour are to be given priority "only in the longer term." The group emphasises that tackling the drinking driver "continues to stand out as a task of particular urgency and importance" yet ignores the fact that we have no information on the distribution and range of blood alcohol concentrations among drivers. "Few new opportunities [exist]," says the group, "for legislation which would be acceptable and offer cost effective means of reducing casualties," although a poll earlier this year showed that three quarters of drivers would be in favour of random breath tests. The report does not even mention random breath tests, which have been shown to be effective in several countries, nor does it discuss enforcing speed limits.

The Secretary of State for Transport's foreword to the report is complacent, pointing out that Britain's accident rate compares well with those of other European countries and has been falling recently. He does not mention that among 5 to 9 year old pedestrians Britain has a higher mortality than almost any other country in the European Community and that among 10 to 14 year olds it is twice the community average. Neither the Secretary of State nor the working group seems to want to upset the motorist by interfering with dangerous habits.

JOHN HAVARD

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- 1 Department of Transport. *Road safety: "the next steps."* London: DoT, 1987.
- 2 World Health Organisation. *Report of the inter-regional seminar on the epidemiology, control and prevention of road traffic accidents, Alexandria, 25 October-1 November 1965.* Geneva: WHO, 1966. (Document WHO/Accid rev/66.6.)
- 3 Bull JP, Roberts BJ. Road accident statistics—a comparison of police and hospital information. *Accident Analysis and Prevention* 1973;5:45-53.
- 4 Hobbs CA, Grattan E, Hobbs JA. *Classification of injury severity by length of stay in hospital.* Crowthorne, Berkshire: Transport and Road Research Laboratory, 1979. (Report LR871.)
- 5 Grattan E, Keigan ME. Patterns and severity of injury in a hospital sample. Paper read at the *Fifth International Conference of the International Association for Accidents and Traffic Medicine, September 1975.* London: IAATM, 1975.
- 6 Stone RD. *Computer linkage of transport and health data.* Crowthorne, Berkshire: Transport and Road Research Laboratory, 1984. (Report LR1130.)
- 7 Tunbridge RJ. *The use of linked transport and health road casualty data.* Crowthorne, Berkshire: Transport and Road Research Laboratory, 1987. (Report RR96.)

### Correction

#### The blood transfusion service and the National Health Service

We regret that an error occurred in last week's leading article by Dr John Cash (p 617). The final page proof was correct when it left the editorial office. The error arose at the printers.

The fifth paragraph should have begun: "What went wrong with the National Blood Transfusion Service—which in the 1950s and 1960s was regarded as pre-eminent in the world? There is no simple answer to this question but part is that the notion that the service was pre-eminent is a misconception. There is and has been no such organisation: it is a myth, a central government fantasy."