If these figures are generally representative and could be substantiated, an area of prevention which has been little explored offers itself.[1]

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Changes in obstetric care in breech births

Sir,
Is obstetric care improving for the breech infant, and if so, in what way? Obstetric records dating back to 1937 were discovered in Barnsley District General Hospital referring to labour suite activities in the original St Helen's Hospital. These were analysed with respect to singleton breech deliveries, their mode and outcome, and compared with singleton breech deliveries taking place in 1982. The current population of the Barnsley area is 233 000. In the early 1940s, three-quarters of deliveries took place at home, whereas nowadays the figure is around 2%.

Hospital breech deliveries between 29 December 1937 and 26 November 1941 were compared with those between 31 October 1982 and 31 October 1984. In the earlier period, 40% of the mothers with a breech infant were primigravid, and in 1982–84, 59%. Equivalent figures for 'grand' multiparas (gravida five or more) are 46% and 9%. Table 1 illustrates the preliminary findings.

The mode of delivery was analysed and the degree of obstetric interference assessed. In Table 2 a complicated delivery refers to one where forceps were used or mechanical difficulties arose, and excludes Caesarian section. An uncomplicated delivery is a straightforward one where the above does not apply.

The difference in the modes of breech delivery between the two periods is striking but not unexpected. The trend towards elective abdominal delivery for the breech infant is illustrated; the policy established by Wright[1] that 'all viable (breech) infants be delivered by Caesarian section' has been favoured until very recently. Amiel[2] considered vaginal delivery to be safer in many ways, and Anderman[3] suggested that carefully selected term breech babies of primiparas could be delivered vaginally with similar perinatal mortality rates to those born abdominally.

'Complicated' deliveries in 1937 included the attachment of weights to the foot in a footling presentation or placenta praevia, and bipolar podalic version. However, it seems that more than half of breech deliveries in this period were uncomplicated.

There was a higher stillbirth rate in 1937–41 (386 per 1000 breech births compared with 6 per 1000 in 1982–84), the causes being cord prolapse, skull fractures, pre-eclampsia, version and obstructed labour. Maternal deaths were variously caused by shock, pyrexia, cardiac failure and gas gangrene.

This small study highlights the dramatic improvement in maternity services over the past 40 years, and illustrates trends in obstetric care.

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Table 1. Comparison of data on breech births in 1982–84 and 1937–41.

	1982–84	1937–41
Total hospital births per year	2572	323
Singleton breech births (%)	166 (*3.2*)	57 (*9.2*)
Perinatal mortality rate (per 1000 hospital births)	9.5	212
Maternal mortality rate (per 1000 hospital births)	0	12.9
Breech perinatal mortality rate (per 1000 hospital births)	48	456
'Breech' maternal mortality rate (per 1000 hospital births)	0	53

Table 2. Comparison of degree of obstetric interference in breech births in 1982–84 and 1937–41.

	Percentage of breech births					
	1982–84			1937–41		
	Primaparas	Multiparas	Total	Primiparas	Multiparas	Total
Complicated deliveries	*5*	*24*	*13*	*35*	*53*	*45*
Uncomplicated deliveries	*6*	*10*	*8*	*61*	*47*	*53*
Caesarians						
Total	*89*	*66*	*79*	*4*	–	*2*
Elective (% sections)	*63*	*42*	*56*	–	–	–
Emergency (% sections)	*37*	*58*	*44*	–	–	–

General practitioners' knowledge about radiology

Sir,
I thought that your readers might be interested in the results of a questionnaire survey carried out by our radiology department recently in an attempt to assess how well-informed were our local general practitioners about both the 'bread and butter' X-ray examinations and also the newer imaging techniques. A total of 75 general practitioners were circulated and 54 responded; the sample included a wide range of practices — service and civilian, urban and rural. A second much shorter questionnaire was given to 50 consecutive patients referred by general practitioners for outpatient procedures, mainly barium studies and intravenous urography, in which they were asked how much information they had been given about the examination by their own doctor, and whether or not they found it useful or desirable.

Of our general practitioner sample 14 (26%) felt that they had insufficient knowledge of the everyday procedures such as bariums and intravenous urograms to inform their patients adequately, and it is possible that this is an underestimate since there have been changes in the way we perform even these basic examinations over recent years. Forty-six doctors (85%) felt that the general practitioner needs to know something about the new 'high-tech' imaging methods, but 43 (80%) said that they had insufficient knowledge in this area.

We also asked a question on the use of the '10-day rule' which showed that 24 (44%) of the general practitioners were applying it inappropriately. Although the 'rule' as such is now obsolete, the answers to this and to another question which dealt with the risk to a fetus inadvertently irradiated during a barium enema, revealed considerable ignorance of basic principles of radiation protection and a tendency to overestimate the hazards involved. This subject was covered more fully in a previous issue of the *Journal.*[1]

Of the patients questioned, 48 (96%) said that they would appreciate some information about their impending X-ray examination prior to attending the hospital, but only 22 (44%) had actually been told anything at all by their general practitioner. I think this is partly a reflection of the tendency of a majority of doctors, including non-radiological hospital doctors, to underestimate the discomfort and worry engendered by, for example, a barium enema or intravenous urogram. However, in the light of the general practitioners' replies to their questionnaire it seems likely that some at least feel unable to advise patients owing to their own ignorance of what actually goes on in an X-ray department.

There were other areas covered in the doctors' questionnaire, notably the use they make of ultrasound and nuclear medicine scans, and how they felt about radiologists giving patients the result of a scan or X-ray at the time of the examination. Space does not permit me to give the results in full, but I was pleased to see that the great majority of our sample accepted that in those procedures where the patient and radiologist came face to face it is unreasonable to expect that there will be no discussion of the findings, always accepting of course that we must then let the general practitioner know what has been said.

I should emphasize that my intention is not to show how ignorant the average general practitioner is about radiology — if anything, I think the results reflect badly on us as radiologists. After all, we are a service specialty, and one of the services that we should be providing is the education of our clients in the most effective use of our resources. It seems that we still have some way to go in this respect.

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Voluntary Service Overseas

Sir,
Recently returned from two years working with Voluntary Service Overseas in a developing country, I have been going through back numbers of the College *Journal* to catch up on current ideas. 'Quality of care' is obviously the phrase of the moment and it is certainly commendable that the College is so dedicated to improving the already high standards here in Britain. However, I could find scarcely a reference to anywhere beyond our shores, let alone the Third World. So let me suggest an increase in interest in primary health care throughout the world — particularly after the College has hosted the 1986 WONCA Conference.

At present doctors going abroad for a period of service get little encouragement from the professional bodies — tightly structured career ladders can make such a step risky. However, most people who take the plunge find the experience worthwhile both personally and professionally and I appeal to the College to find ways of promoting such activity. Voluntary Service Overseas has several vacancies at present in primary and secondary health care, and the organization would be delighted if the Royal College of General Practitioners would sponsor a primary health worker. How about it?

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Diabetes and driving

Sir,
The Medical Commission on Accident Prevention recently reported that many newly-diagnosed diabetics fail to report their condition when making initial or renewal application for a driver's licence, that 'the British Diabetic Association strongly advises insulin-treated diabetics against taking employment requiring a vocational licence', and that diabetics who do not require insulin 'should be advised not to enter an occupation which involves vocational or comparable driving responsibilities'. They also reported that 'the World Health Organization and the British Diabetic Association recommend that private car licences should be issued only when diabetic control is good and the level of understanding of diabetes management by the patient is adequate'.[1] This advice, however, is not widely understood by the public.

We have just completed a questionnaire survey of employed persons in Avon County, England, to ascertain what non-diabetic adults understand about diabetes. The response rate was 71% (500 out of 709). Among these respondents, 63% did not know that some people with diabetes are not allowed to drive a car, 62% did not know that some diabetics are barred from driving heavy goods vehicles, and 61% did not know that some diabetics are not permitted to drive public service vehicles. There were no statistically significant differences in knowledge between males and females or social class groups.

Although diabetic patients are responsible for reporting their condition to the Driver and Vehicle Licensing Centre at Swansea, it is often not declared.[2,3] There are also reported deficiencies among medical practitioners in knowledge regarding diabetes and driving.[4] Our findings reinforce the need to advise newly-diagnosed diabetics about driving and health and of their legal responsibility to declare the condition.

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Corrigendum

In the letter 'Arthralgia from parvovirus infection' (June *Journal,* p.288) the first reference was incomplete. The complete reference should have read: White DG, Woolf AD, Mortimer PP, *et al.* Human parvovirus arthropathy. *Lancet* 1985; **1:** 419-421.