and safety, the optimal way of managing preterm labour will remain an area of uncertainty.

Preterm babies were not the focus of our paper, however. As we clearly stated, we were studying term, singleton, non-malformed babies who later developed cerebral palsy. It is within this group, who seemed to have no other risk factors (although we did identify an excess of antenatal risk factors among those with cerebral palsy compared with the controls) that the "obstetrically preventable" group is likely to be found.

Beavis challenges the criteria of suboptimal care used; of course, few of the criteria we used have ever been scientifically tested, no more than the stricter criteria of suboptimal care which he suggests. Evidence based care is as lacking in obstetrics as in most other fields of medicine. Until such evidence is available, a consensus view is used as a substitute. If there is a consensus among obstetricians that stricter criteria should be adopted, then presumably the frequency of instances of "suboptimal care" in cases of cerebral palsy will increase, as will the frequency of "suboptimal care" among normal controls. It is important to realise that even with the criteria we used, there was a failure to respond appropriately to fetal distress in 7% of the normal controls.

In our view, therefore, the way forward lies not only in refining standards of obstetric care by critical evaluation of current practice but also in research into the many factors which can alter the normal development of the brain.

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Trust hospitals and vascular services

See also page 387

EDITOR,—We write to express concern over the detrimental effect that trust hospitals are having on strategic planning for vascular services. Many recent consultant appointments have been of singlehanded vascular surgeons in district hospitals as they adopt trust status. The proportion of singlehanded surgeons fell from 43% to 7% between 1988 and 1992 but will inevitably rise as a result of these appointments.

This problem has recently been highlighted in South West Thames region, where retiring singlehanded vascular surgeons have been automatically replaced at separate but adjacent hospitals and the opportunity for rationalisation and improvement in services and training has been missed. Despite inquiries by the regional adviser there seems to be no mechanism by which separate hospitals can combine to deliver a coordinated modern service. Furthermore, 30-50% of admissions for vascular surgery are either urgent or emergencies, and no singlehanded vascular surgeon can provide a round the clock emergency service—nor, for that matter, can a two person vascular unit—without considerable personal sacrifice and stress. In many district general hospitals this is solved by including general surgeons on rotas for emergency vascular surgery. Emergency vascular surgery, however, is often demanding, and it is inappropriate for surgeons who perform no elective vascular surgery to find themselves dealing with ruptured aneurysms or ischaemic legs. Transfer to an appropriate unit is preferable to inadequate cover in every hospital.

The national confidential enquiry into perioperative deaths advised that aneurysms should be treated by vascular surgeons since their results are much better than those of general surgeons.[1,2] The same argument applies to the treatment of ischaemic legs, in which a multiskilled team approach, allowing the appropriate selection of surgery, thrombolysis, and balloon angioplasty, is particularly important.[3]

These considerations led a working party of the National Medical Advisory Committee for Scotland (population 5·1 million) to recommend that the number of hospitals providing vascular services should be reduced from the present 20 to six major centres and three intermediate units.[4] The vascular advisory committee of the Vascular Surgical Society of Great Britain and Ireland therefore wishes to persuade trusts throughout Britain that patients are not well served by a sporadic service; to provide full cover for vascular emergencies a district general hospital needs three vascular surgeons and therefore a population base of about 600 000. The surgeon then provides emergency cover on a 1 in 2 rota for three to four months of the year and on a 1 in 3 rota for six months of the year, allowing for holidays and study leave. With the introduction of the shorter, seamless training scheme vascular surgeons will be much less protected by surgically competent junior staff and even this on call rota will be onerous.

Trust hospitals have the right to work independently, but without a regional strategy patients will continue to suffer from the vagaries of an uneven service. The patients who suffer may resort to litigation, and improving audit will support their case.

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1 National Confidential Enquiry into Perioperative Deaths. *Report.* London: NCEPOD, 1990.
2 Gruer R, Gordon DS, Gunn AA, Ruckley CV. Audit of surgical audit. *Lancet* 1986;i:23-35.
3 Holdsworth J, da Silva AE, Harris PL. Survey of clinical outcome from the management of critical limb ischaemia in Great Britain and Ireland. *Br J Surg* 1994;81:607-22.
4 National Medical Advisory Committee for Scotland. Report on vascular surgery services in Scotland. Edinburgh: HMSO, 1993.

The Hippocratic oath

EDITOR,—In the Editor's Choice in the issue of 9 July the editor asked, "When did medical schools stop administering the Hippocratic oath and why?" Perhaps the question should be, was it ever administered in any medical school at any time, and if so where and when?

There is a widespread public belief that the oath is still administered to all doctors on graduation. "I am a veterinary surgeon," wrote the author of a personal view earlier this year; "I have taken no Hippocratic oath."[1] Neither have I. Neither has any doctor I know. At best I have heard vague rumours that the oath is, or was until recently, administered in some universities in some countries, but those rumours have never been substantiated.

The usually reliable Garrison, author of the medical historian's "bible," wrote in 1929. "The oath has been administered to medical graduates in many European universities for centuries."[2] He failed, however, to provide any evidence. Medical and medical-historical dictionaries, encyclopaedias, "companions," and publications on medical ethics frequently deal with the oath at length and emphasise its importance in the development of medical ethics; but none that I have seen provides evidence of the oath actually being administered in a medical school.

My own research has included the history of the medical profession and medical education since the beginning of the 18th century. I have searched for but failed to find even a shred of evidence that the oath was administered anywhere at any time. Negative evidence, of course, is notoriously difficult to prove. Possibly at some time in the past administration of the oath was such a routine procedure that no one mentioned it. I suspect, however, that the administration of the oath to medical graduates is, and possibly always was, a myth. But it is such a powerful myth that I say so with trepidation and expect to be proved wrong.

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1 The right to die. *BMJ* 1994;308:66.
2 Garrison FH. *An introduction to the history of medicine.* 4th ed. Philadelphia, London: W B Saunders, 1929:96.

Nestlé's donation

EDITOR,—The letter from Nellie Adjaye and others about Nestlé's donation to the British Paediatric Association to further the work of its research unit contains two important errors of fact.[1] The current policy of the British Paediatric Association is to accept donations from commercial companies whose products are not harmful and whose marketing practices obey the ethical standards set by the codes of the countries in which they operate. This policy has been considered many times over the years and was agreed unanimously by the association's council in October 1989 after a lengthy discussion. The council is the democratically elected body of the association and appropriately representative of all the association's members. The association receives donations from several other manufacturers of infant foods, and there was no reason why this donation from Nestlé should have been treated differently. Since acceptance of the donation was in accordance with current policy it is peculiar to suggest that the association tried to conceal it. The association had no reason to do so.

Adjaye and others also state that "Nestlé (UK) Ltd requested that acceptance be confirmed by the British Paediatric Association's council as soon as possible." This is not correct; nor was it necessary. Nestlé indicated that it "would wish that the company received due recognition of the donation as you and your council feel appropriate."

On 24 June this year the association's council reaffirmed, by a large majority, its policy to accept donations from commercial companies and confirmed that the honorary officers had acted properly in accepting the donation from Nestlé. The council noted with regret that errors had been made in reporting this donation in the standard way to the council and the membership but was satisfied that there had been no intent to mislead the membership. Steps have been taken to ensure that all future donations are recorded and notified in the standard way.

The general principles of commercial sponsorship will be discussed again by the council in October, when further information will have been gathered by a small working party.

K L DODD

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1 Adjaye N, Beesley JR, Brewster N, Bush A, Carter PFB, Carter E, *et al.* Nestlé's donation. *BMJ* 1994;309:276. (23 July.)

Correction

Health and safety at work

A typesetting error occurred in this letter by H G E Wilson and R M Agius (16 July, pp 198-9). The second sentence of the second paragraph should begin: "The correct balance must be found in 're-regulation [not regulation] rather than deregulation.'"