audit of the rate of testing and to allow public health doctors to exert leverage by setting expected testing rates as part of the commissioning process.

An intercollegiate working party on antenatal HIV testing, including representatives of the royal colleges of midwives, obstetricians and gynaecologists, physicians, and general practitioners, among others, has prepared recommendations to reduce vertical transmission of HIV in the United Kingdom by increasing voluntary confidential HIV testing. It is addressing the issues considered above, but to be more effective than the current Department of Health guidelines it will need to be followed by a detailed implementation plan.

The indifference of some obstetricians and an unwillingness by many midwives to broach the issue of testing has meant that Britain has fallen behind other countries in providing pregnant women with access to HIV testing. It is shameful and negligent that we have counted the number of babies at risk of infection since 1990 without acting to reduce their risk.

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Reducing road traffic

Would improve quality of life as well as preventing injury

On a balmy summer afternoon in London in 1896 Bridget Driscoll stepped off the kerb and into history as the first person to be killed by a car in Britain. At her inquest the coroner said he hoped such a thing would never happen again. Over the next 100 years, 475 000 people would die on Britain's roads, with 30 times as many seriously injured.[1] So many deaths could not go unnoticed, but the effect of motorisation on walking very nearly has.

The Road Traffic Reduction (UK Targets) Bill has its second reading next week. If it is enacted the Secretary of State will be required to implement policies to reduce road traffic by 5% by 2005, and by 10% by 2010. The bill is supported by a host of health, welfare, and environmental groups, including the BMA, Barnardos, the Child Accident Prevention Trust, the Children's Play Council, the Faculty of Public Health Medicine, Friends of the Earth, and the Royal College of Paediatrics and Child Health. Their concern is not only to reduce death and injury but also to counter the other adverse effects of motorisation.

Car travel has decimated walking. National estimates of walking mileage first became available in 1972. Since then the annual average distance walked has fallen by 22%.[2] The decline is greatest in 5-15 year olds, in whom mileage has fallen by 28%.[2] A quarter of all car journeys are under two miles (3.2 km), and the proportion of children travelling to school by car has increased from 12% in 1975 to 23% in 1994.[2]

The equation of transport policy with road traffic policy has left children, elderly people, and those without a car socially excluded in our "top gear" towns. Children are prevented from playing in the street and travelling independently[3]; adults without cars are excluded from out of town supermarkets and inconvenienced by edge of town hospitals poorly served by public transport.[4] Yet both are included in injury statistics and suffer more than their share of noise and pollution.[4] For many children being struck by a car is their first experience of car travel, and the risk of injury for children in families without a car is twice that of children in car owning families.[5] This, and the familiar scenario of the elderly pedestrian waiting anxiously at the kerb, surely deserves the attention of any Downing Street social exclusion unit.

A three kilometre walk uses up about half the energy in a small bar of chocolate.[6] The same distance by car expends 10 times as much energy and from the wrong source.[7] As physical activity and thus energy output has declined, the prevalence of obesity has increased.[8] Inactivity contributes to cardiovascular disease, diabetes, osteoporosis, and hypertension.[8] On the other hand, energy consumption by road transport is increasing rapidly.[9] Private cars account for one eighth

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of all carbon dioxide emissions, and vehicle exhaust is a potpourri of pollutants.[10]

Preventing disease and injury may not be the most persuasive reason to reduce car use: improving quality of life should be the stimulus for change. Urban living would be more enjoyable without the drone of traffic, the smell of exhaust, and the danger. Bumping into someone in the street could be a welcome opportunity for interaction, not the precipitant of road rage. Less traffic might regenerate the supportive social networks of community interaction and revitalise our inner cities. And congestion is bad for business. The Confederation of British Industry estimates that road congestion costs Britain £20 billion a year.

As a private member's bill the Road Traffic Reduction Bill will need government support to succeed. The Department of the Environment, Transport, and the Regions has already made clear its intention to get people out of their cars, and the bill provides it with an opportunity to match its concern with commitment. Neverthless, the bill does have political enemies in the shape of a well organised road lobby, representing those who sell cars, roads, and petrol, and even with government support may face parliamentary obstructionism. Those MPs who are tempted to filibuster should think instead about the quality of life of their own and their constitutents' children.

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Is clinical effectiveness a management issue?

Yes, doctors and managers need each other to implement evidence based practice

Action on clinical effectiveness is showing that success in implementing evidence based practice is achieved only when there are real local partnerships between clinicians and managers. The challenge is not to turn clinicians into managers but to recognise that some aspects of the task are the direct responsibility of managers. The recent white paper on the NHS, with its emphasis on quality and concept of clinical governance,[1] has given added impetus to the creation of these partnerships. The requirement for chief executives of trusts to make "appropriate local arrangements" may make little progress unless doctors and managers reach a shared understanding of their distinct contributions to the development of evidence based practice and generate enthusiasm for the approach in organisations.

Progress may be contentious because some clinicians are sceptical about the interest of managers in clinical effectiveness and evidence based practice.[2] Clinicians are usually interested—and excited—by discussions about research, but their interest wanes when those discussions progress to questions about the routine use of research findings. Interest in implementation is often viewed as yet another means of influencing clinical decisions or, more cynically, as a means of reducing resources.

Improved access to research evidence has stimulated interest in implementing evidence based practice[3] in order to improve the quality of health care, reduce variations in the delivery of health care, secure a better return on the extensive investment in research, and minimise clinical risk. Early examples of implementation projects included the use of corticosteroids in preterm delivery in Oxford[4] and the use of aspirin in secondary prevention of cardiovascular disease in Sheffield.[5] More recently several other projects have been launched, including a programme involving all health authorities in the North Thames region and a major national programme, Promoting Action on Clinical Effectiveness (PACE), which was launched in 1995 and is based at the King's Fund.

The programme includes 16 projects working on a range of 10 clinical conditions. These projects are showing that a focus on a clinical topic can encourage changes in clinical behaviour. For example, the Bradford project is aiming to change clinicians' prescribing practice in order to eradicate *Helicobacter pylori*, the Chase Farm project to improve the management of pressure sores, and the North Derbyshire project to improve the treatment of cardiac disease.[6] Project work also identifies areas where local partnerships and clarity about the roles and responsibilities of clinicians and managers are important.

In fact, clarity about responsibilities is a prerequisite for success. Clinicians need to review local practice against available evidence and help determine priorities for change—a subsequent task to be handled jointly by clinicians and managers. The Bromley project has shown that discussions about respsonsibilities can promote understanding about the overall task. Managers can help ensure adequate resources and bring project management skills to the task. This is important because coordinating the work may be time consuming: many projects need to work in both primary and secondary care and involve a wide range of disciplines. The Royal Berkshire project has shown that communications are an essential shared responsibility so that all those likely to be affected by a change

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