predictions of impact to such an extent that the standard model of health impact assessment should be abandoned. Instead, we recommend that local decision makers adopt a process of mini health impact assessment, whereby a reduction in the time and effort dedicated to individual interventions will result in little or no loss of information gained. A robust evaluation of the impacts of community based interventions will need substantial investment in maxi health impact assessment.

Competing interests: None declared.

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(Accepted 25 June 2001)

Corrections and clarifications

Editor's Choice
In the third paragraph of the Editor's Choice ("Aspiring to be global") of 11 August we twice referred to infants aged under 3 months in relation to breast feeding in Latin America. We should have said "infants aged under 4 months" as described in the paper by Ana P Betrán and colleagues ("Ecological study of effect of breast feeding on infant mortality in Latin America"), pp 303-6 of the same issue.

Risk of adverse birth outcomes in populations living near landfill sites
In this article by Paul Elliott and colleagues (18 August 2001), we inadvertently published a map of Great Britain that included the Isle of Man. We should have known better. The Isle of Man is not part of Great Britain (or the United Kingdom); it is a Crown dependency. But it does have a landfill site, according to a general practitioner from that island, who kindly alerted us to our geographical inaccuracy.

Just in time

In 1969 I was involved with the start of the programme of higher training for ambulance crews. Little did I think that, 20 years later, this innovation would save my life.

In 1989 I was helping my daughter to move into her new house in Lancashire. I was uncomfortable from persistent "indigestion," and, after several pints of milk, I noticed that the pain was spreading down my left arm. The penny dropped, and I realised that I was suffering from acute angina pectoris. My daughter summoned an ambulance, which came commendably quickly, and I was gently lifted in and made comfortable in the back. My daughter explained to the ambulance crew that I was an anaesthetist. They had had higher training, and I was offered the choice of plain oxygen or Entonox. As the pain had lessened, I chose plain oxygen. A direct writing electrocardiograph was attached, and I was offered the trace. Even I was able to recognise the gross ST depression, and I suggested that the ambulance men turn on their siren and blue light and get a move on.

They did as I suggested and radioed ahead to the Royal Preston Hospital. On arrival, I was carried into the accident and emergency department and put on a couch in a half sitting position. Several doctors and nurses surrounded me. A second electrocardiograph was attached and an intravenous cannula inserted, and I was given some diamorphine. At that point, I clearly recall saying, "I think I'm going to faint." The next thing I knew, I was lying flat, and there was a ring of faces looking down at me. I had a curious warm glow in my chest. I spoke to the prettiest face (who turned out to be the house physician) and said, "You have defibrillated me haven't you?"

"Yes," she said, "but you only needed 200 joules."

The rest is history. After a few days in the coronary care unit and another attack of acute angina (without an arrest), I was transferred for coronary angiography and angioplasty. I went home a few days later and now, another myocardial infarction and a triple bypass later, will soon be celebrating my 73rd birthday, and, I hope, am good for a few more yet. I remain in touch with the ambulance service, doctors, and nurses who, between them, substantially extended my life.

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