We will consider for publication only letters submitted in duplicate, printed in letter-quality type without proportional spacing and not exceeding 450 words. All the authors must sign a covering letter transferring copyright. Letters must not duplicate material being submitted elsewhere or already published. We routinely correspond only with authors of accepted letters. Rejected letters are destroyed. Accepted letters are subject to editing and abridgement.

Seules peuvent être retenues pour publication les lettres reçues en double dont la longueur n'excède pas 450 mots. Elles doivent être mécanographiées en qualité «correspondance» sans espacement proportionnel. Tous les auteurs doivent signer une lettre d'accompagnement portant cession des droits d'auteur. Les lettres ne doivent rien contenir qui ait été présenté ailleurs pour publication ou déjà paru. En principe, la rédaction correspond uniquement avec les auteurs des lettres retenues pour publication. Les lettres refusées sont détruites. Les lettres retenues peuvent être abrégées ou faire l'objet de modifications d'ordre rédactionnel.

Childhood injuries

Dr. Amir Shanon and colleagues, in their article "Nonfatal childhood injuries: a survey at the Children's Hospital of Eastern Ontario" (*Can Med Assoc J* 1992; 146: 361-365), remind us of the all too frequent occurrence of injuries in children, particularly those under 4 years of age. They emphasize that 45% of these injuries occur in the home, as do 82% of burns suffered by young children. Because of this, they state that "priority should be given to research into and educational programs for the prevention of such injuries as falls, burns and poisonings among younger children at home."

This problem has been with us indefinitely, and our educational efforts do not seem to be adequate in reducing the number of mishaps that befall young children. Most family physicians and primary care pediatricians spend time in anticipatory guidance to parents, as do public health nurses in their clinics. Most parents who present in emergency departments with injured children are aware that the event might have been avoided, which raises the question of use of the term "accident."

By definition, an accident is an event that could not have been anticipated, avoided or prevented. Thus few real accidents happen to young children at home. Almost exclusively they are the result of failure in prevention by the caretaker. We will never succeed in raising the profile of the problem and creating greater awareness in parents if we continue to use the euphemisms "accident" and "mishap." We have to place the responsibility where it belongs.

It's easy to understand why we are reluctant to do this. Injuries to children in the home occur so easily that inevitably we feel compassion for the parents and appreciate their guilt, recognizing that our own children have suffered too. In essence, we are often guilty of collusion with parents in an unconscious effort to avoid identifying the failure to protect.

We must explore the dynamics of the event to define what circumstance created the risk for the child. In some instances it may be lack of knowledge, especially about early developmental activities (e.g., when infants roll off a change table). This is where anticipatory guidance belongs. But what about repeaters? We don't do a very good job of recognizing children who have more than their share of injuries, largely because we don't make a point of seeking out the emergency department record each time the child attends or because the information is dispersed among several city hospitals. Were we to explore the past history of injuries routinely, we might be quicker to recognize children who live with a greater than acceptable risk.

The child may, of course, be "accident prone." This is a useful term when we are exploring the history with the parents, but it is not a correct one. The real term should be "accident-prone family." A parent may be overwhelmed by a multiplicity of tasks, all of which require attention at the same moment, such that anticipation of a risk to the child is delayed. Parents may be preoccupied with their own needs (because of physical illness, mental distress or conflicts with each other) or, unfortunately but only too frequently, their own interests and pleasures, all of which create unguarded moments for a child.

In my experience, once one puts such explorations in the context of constructive help, parents are all too willing to commit time to a future discussion on how they might make things safer for their child. Often they appreciate the attention to their problem. Sometimes the issue is their inability to exercise effective control, and the task is to help them, so that the next time they warn the child, the child will take notice.

Keep Your Child Safe, edited by Dr. Richard Stanwick, is an insightful and well-written document published in 1991 by the Canadian Paediatric Society and Ross Laboratories. It is available from Ross (514-340-7100) and

← For prescribing information see page 1857

should be in the offices of all family physicians.

In summary, I agree with Shanon and colleagues that we need to be doing more, but I also think we need to be doing it with insight. We should banish the term "accident" and, after excluding assaultive trauma and dealing with immediate needs, approach each incident by exploring the dynamics of the event (and of the family), checking the past history, inquiring about "accident proneness" and offering help. In some cases a refusal to accept constructive help in prevention of risk may constitute grounds for a report to a child protection agency.

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I was pleased to read the article by Dr. Shanon and colleagues. The authors' call for prospective multicentre studies on childhood injuries has been partially answered by the establishment in 1990 of the Children's Hospital Injury Research and Prevention Programme (CHIRPP). I write "partially" because CHIRPP is a sentinel child injury surveillance program, not a prospective study.

In this program detailed information on injured children presenting to the emergency department of participating hospitals is obtained from the adult accompanying each child and from the attending physician and is entered on the CHIRPP data collection form. These hospitals — Canada's 10 pediatric hospitals plus 2 general hospitals (Hôpital de l'Enfant-Jésus, Quebec; and Stanton Yellowknife Hospital) — send the data to CHIRPP's national office, at the Laboratory Centre for Disease Control, Ottawa, for entry into the national database (usually within 2 months of occurrence of the injury) and for epidemiologic analysis. CHIRPP is funded by the federal government, with start-up contributions from Hewlett-Packard Canada and Berol Canada.

With its timely capability of identifying the patterns of how, when, where and why Canadian children are injured, CHIRPP is an exciting initiative that will facilitate the design, implementation and evaluation of effective intervention programs. Readers are welcome to contact me for more information about CHIRPP.

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Ten years of AIDS

Any journal with a tombstone on its cover is bound to be depressing. The Feb. 1, 1992, issue of *CMAJ* was no exception.

The mention of my former laboratory partner at an Ottawa course in epidemiology in 1973, Dr. Gordon Jessamine, as a Canadian pioneer in acquired immunodeficiency syndrome (AIDS) research (*Can Med Assoc J* 1992; 146: 369-370) was probably the only item with which I was happy.

In "Ten years of AIDS: The GP's perspective (*ibid:* 378-380) I admired Dr. Philip Berger's compassion and courage to speak his mind and can empathize with his involvement because of my own experience with childhood leukemia. However, I find myself in diametric opposition to his approval of AIDS activism.

Dr. Catherine A. Hankins mentions Canada's endorsement of the World Health Organization's guidelines for human immunodeficiency virus (HIV) testing — the three "C" conditions of counselling before and after testing, informed consent and confidentiality ("Ten years of AIDS: AIDS has changed medicine and the way it is practised" [*ibid:* 381-382]). As one of the angry physicians she describes I would add two more "C"s: capitulation to the disease — the epitome of craziness. Ten years of AIDS has indeed changed the integrity of medicine.

The endorsement of pornography, as exemplified by the safe-sex posters so ably displayed by Professor James Miller and Dr. Iain Mackie ("After 10 years of AIDS, safe-sex message still controversial" [*ibid:* 383-384]), is an example of the "C"s that I have added.

Finally, the headline of Lynne Sears Williams' article "Even milk banks for preemies have been affected by AIDS" (*ibid:* 385)) appears to belie the statement attributed to Dr. Andrew Stewart that "there has not been a documented case of AIDS being transmitted by human bite or by any other body fluid except blood or semen."

There have been published cases of horizontal transmission of HIV infection between two brothers in whom bite marks were found[1] and between sisters.[2] Infection from breast milk is clearly documented.[3] There is also the matter of the dentist-related cluster of HIV cases in Florida.[4]

Returning to your rather depressing cover photograph, even the inscription AIDS on the tombstone is wrong. It should read TRUTH!

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