social worker for the child. Who looks after the family? A guardian ad litem may be appointed (with his or her own costly legal representation), but the guardian's role is specifically to ensure the welfare of the children. There is a desperate need for a social worker for the family, to provide unbiased advice, explain parents' rights, and support the family at complex conferences.

Current practice undermines not only the family but also the key social workers, whose therapeutic relationships and opinions are not valued. Overspent, uncapped budgets are used to obtain assessments and therapy from outside social services. Practice varies enormously between teams in the same authority. Foster care is overflowing with children, and its use should be audited.

Professionals reading of the heartbreaking cases in which a child has died realise that social services have addressed the causes thoroughly: they now use this system for all disclosures. Referrals to social services are not neutral and may not remain confidential; they may be very damaging. I would support any doctor who thinks carefully before making a routine referral to social services.

DAVID FISH
General practitioner

Henley Green Medical Centre,
Coventry CV2 1AB

1 Child protection: medical responsibilities. *BMJ* 1996;**313**: 671-3. [With commentaries by F N Bamford and I Heath.] (14 September.)
2 Gibbons J, Conroy S, Bell C. *Operating the child protection system.* London: HMSO, 1995.
3 Bullock R, Little M, Millham S, Mount K. *Messages from research.* London: HMSO, 1995.
4 Reader P, Duncan S, Gray M. *Beyond blame.* Oxford: Routledge, 1993.

Child's needs should be central

EDITOR,—I am concerned about some of the issues raised in the case discussed in the ethical debate about child protection.[1] Given the nature of the case, it is entirely appropriate that social workers should have investigated it, as it was indeed an abuse of parental responsibility towards a child. I am not surprised at the child claiming that she must have slept through anything that happened. I have seen a teenage girl who denied the possibility of being pregnant despite having had no period for three months and having recurrent bouts of morning sickness, a positive result on pregnancy testing, and a viable first trimester fetus visible on ultrasonography. I suspect that the response of the child in the case debated reflects the human psyche's ability to deny unpleasant facts and should not be taken at face value.

The author tries to take an overview of his or her relationship with the entire family, with the result that the child's needs have become more peripheral than they should be. As medical professionals, we can manage only certain aspects of such complicated cases, and I believe that we are doing a disservice to the child if we do not involve other professionals more capable of continuing the investigations. It is by no means always the case that incest is disclosed at the time of a teenage girl's pregnancy being discovered. I would caution against the belief that "careful advice coming from a trusted doctor" is the input that a sex abuser needs.

Iona Heath's remark in her commentary on the case—that the outcome of these interventions rarely seems adequate—reflects a natural desire for a solution to what is an almost irreconcilable situation. My experience in paediatrics suggests that it is important not to ignore evidence that contradicts an apparently plausible explanation of such situations. I think that we do a disservice to young people, who need a voice and an advocate on their behalf. All too many victims of familial sexual abuse suffer in the long term; they are likely to leave home, which puts them at risk from other dangers, such as prostitution, drugs, and violence. We want to prevent the abused person from becoming a potential abuser. We protect the perpetrator at great risk to the victim.

A F MELLON
Consultant paediatrician

District General Hospital,
Sunderland SR4 7TP

1 Child protection: medical responsibilities. *BMJ* 1996;**313**: 671-3. [With commentaries by F N Bamford and I Heath.] (14 September.)

Girl should have been offered a chance of safety

EDITOR,—I read the recent ethical debate on child protection with increasing uneasiness.[1] Although the priority of the child's welfare and the danger of professionals "going it alone" are pointed out, other important issues are not addressed.

Did it not seem worrying to the general practitioner that the girl behaved as she did when the allegations were made? Phrases such as "she offered no explanation" indicate to me a lack of insight into her experiences. Children subjected to sexual abuse, especially over a long period, may be unable to confirm that it occurred, even when there is irrefutable medical evidence. In this case, fetal DNA from samples obtained after termination of her pregnancy matched that of her stepfather. Her denial probably arose out of fear of her abuser. It would take a long time for such a child to trust any adult to keep her safe. In this case she was right not to "offer an explanation": hopefully, that provided her with some protection when the judge decided that this family should remain intact.

The general practitioner talks of the "so called abuser." Impregnating a 14 year old girl would count as sexual abuse to most people; having been sexually abused as a child is an explanation but not an excuse. It seems that the abuser was not asked to take any responsibility for his actions but was allowed to remain at home. What message did this give him for the future?

Did the general practitioner see no way of supporting the mother in protecting her children?

If anything, this case report is an example of how child abusers can seduce and split professionals, no matter how experienced they think they are. No one says that the system we have now is perfect, but it is, as it must be, child centred. Not all residential care units or foster homes are abusive. I wonder if this girl, if given a chance of safety, would have been able to offer an explanation to satisfy her general practitioner.

JULIET BUTLER
Senior registrar in child and adolescent psychiatry

Child Protection Team,
Department of Psychological Medicine,
Great Ormond Street Hospital for Children,
London WC1N 3JH

1 Child protection: medical responsibilities. *BMJ* 1996;**313**: 671-3. [With commentaries by F N Bamford and I Heath.] (14 September.)

Prodigy, a computer assisted prescribing scheme

Interim data show that it is worth taking the scheme further

EDITOR,—I wish to address the criticisms of the computer assisted prescribing scheme Prodigy that Iain E Buchan and colleagues raise.[1] Prodigy is an innovative project that seeks to involve practising general practitioners in evaluating and refining a product intended for use by general practitioners. The primary role of the Sowerby Unit for Primary Care Informatics at the University of Newcastle is to evaluate rigorously and objectively the results of the various phases of testing and to highlight their implication for improving the prototypes. I believe that the collaborative methodology that has been used is new to the NHS and has merit (I N Purves *et al*, annual conference of primary health care specialist group of British Computer Society, 1996). The Prodigy team has received, sought out, and welcomed criticism from health service researchers and people working in health informatics around the world.

An interim report on Prodigy was written to inform the community in a politically charged atmosphere.[2] The report is clearly a snapshot of currently available information, with conclusions based on a number of evaluations (I N Purves *et al*, annual conference of primary health care specialist group of British Computer Society, 1996).[2] Quotes by Buchan and colleagues originate from the conclusions of the report but were not immediately linked to the data in the way that their letter suggests. Buchan and colleagues juxtapose the quoted conclusion of "'confirming [the] desirability'" of Prodigy to the responses to the question "How much would you want to continue with Prodigy?,"[1] but the text that was juxtaposed in the report was "94% ... consider Prodigy to be a concept worth developing (16% being extremely happy, and 78% endorsing its development as long as either 'some improvement' or 'significant improvement' is made)."[2] This is not confirming desirability but supporting a concept. Similarly, the interim report does not claim that Prodigy's "'effectiveness' is confirmed"[1] because of "'relative reduction in the rise of expenditure of 1.1%.'" In fact it states, "At this early stage we have insufficient data ... to make any statistical inferences."[2] Finally, Prodigy has been "thrust" on no one: all 137 sites using it volunteered.

Prodigy is a combination of active and passive systems. It is not ready to be rolled out: the data in the interim report suggest only that the concept is acceptable and worth taking further. Prodigy is an innovative yet practical step in clinical computer systems, and one has to start somewhere. Reliable and statistically robust conclusions will be possible once the study is completed; only then will we be in a position to judge the merit or otherwise of Prodigy.

IAN PURVES
Director

Department of Primary Health Care,
University of Newcastle,
Newcastle upon Tyne NE2 4HH

1 Buchan IE, Hanka R, Pencheon D, Bundred P. Introduction of the computer assisted prescribing scheme Prodigy was premature. *BMJ* 1996;**313**:1083. (26 October.)
2 Purves IN. *Prodigy interim report.* Newcastle upon Tyne: Sowerby Unit for Primary Care Informatics, University of Newcastle, 1996.

Decisions will be taken after receipt of final report next autumn

EDITOR,—I wish to provide some background to the computer assisted prescribing scheme Prodigy, which Iain E Buchan and colleagues criticise.[1] Prodigy is a three year research and development project whose main aim is to test the likely acceptability of decision support for prescribing in general practice. The evaluation aspects of the report are the responsibility of Dr Ian Purves and his team at Newcastle upon Tyne. No decisions will be taken on whether to proceed to any form of national implementation until the NHS Executive has received the final evaluation report, due next autumn.