This threat carries with it the sense of punishment for the child's inability to cope with the responsibilities of caring.[10] Thus the child carries a double responsibility—not only the practical day to day caring but also the strain of attempting to do it "well enough" to avoid separation and disintegration of the family.

In schools, where teachers and education social workers might be expected to be supportive, the response has again usually been disciplinary intervention and prosecution rather than any attempt to understand the needs of the child.[5]

The services that these children provide go far beyond the boundaries of "helping out a bit"—an acceptable, healthy part of family life—and become instead a responsibility that carries with it profound implications for the social and educational development of the child. Attendance at school suffers, which restricts opportunities for future development, and friendships and social life are limited by the extent to which the child has to fulfil the caring role. In effect, children lose their childhood. As such, they require recognition, support, and help in two specific ways, one as a child in need and the other as a young carer.

Under the Children Act 1989 every local authority has the duty to "safeguard and promote the welfare of children" and to provide a "range and level of services appropriate to those children's needs."[11] The NHS and Community Care Act 1990 requires assessment of carers' needs and emphasises consultation and negotiation with carers; it fails, however, to address the issue of young carers. As long as these children remain unidentified both as young carers and as children in need they will be beyond the reach of these services, to which they have a fundamental right.

Aldridge and Becker have suggested that the lack of effective services to offer young carers has influenced the inability—or unwillingness—of professional providers of care to identify these children.[12] If there are no resources—time, money, or staff—"ignoring" the situation may seem wiser. Now, however, several schemes exist to assess and support the needs of young carers.

The work of the young carers projects of the Carers National Association has done much to raise public awareness and empower young carers in the community.[13] Regional health authorities have funded various projects, including those in Sefton and St Helens on Merseyside, while in Bradford and Gloucestershire two "young carers development workers" are being jointly funded by the NHS and social services. In Leeds there are plans to launch a befriending scheme—similar to the buddying project established for people with AIDS—and in Kingston there is a helpline for young carers staffed by school nurses and an education welfare officer. Through community care plans and children's plans, all districts should now take the opportunity to strengthen interprofessional working practices and formulate policies and guidance to meet the needs of these children.

Recent research—most notably by Aldridge and Becker[5]—has established that what young carers desperately need is someone to talk to; to listen to them sensitively and respectfully; and to believe them when they describe the circumstances in which they live. The more we are prepared to listen the more we will be able to identify those children who are young carers. Hopefully, we will then be better able to offer the help and support that they need and deserve.

As Aldridge and Becker say, "To neglect these children... is not simply a matter of oversight, but arguably is an abuse of their rights, dignity and childhood."[10]

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1 Fallon K. An involuntary workforce. *Community Care* 1990 Jan 4:12-3.
2 Meredith H. Young carers, the unacceptable face of community care. *Social Work and Social Sciences Review* 1991;3(suppl):47-51.
3 O'Neill A. *Young carers; the Tameside research.* Manchester: Tameside Metropolitan Borough Council, 1988.
4 Page R. *Report on the initial survey investigating the number of young carers in Sandwell secondary schools.* Sandwell: Metropolitan Borough Council, 1988.
5 Aldridge J, Becker S. *Children who care - inside the world of young carers.* Loughborough: Department of Social Science, Loughborough University, 1993.
6 Honigsbaum N. *HIV, AIDS and children: a cause for concern.* London: National Children's Bureau, 1991.
7 Grimshaw R. *Children of parents with Parkinson's disease: a research report for the Parkinson's Disease Society.* London: National Children's Bureau, 1991.
8 Bilsborrow S. *You grow up fast as well...young carers on Merseyside.* London: Carers National Association, Personal Social Services Society, and Barnardos, 1992.
9 Meredith H. Developing support for young carers. *The Carer* 1991;16:Jan:9.
10 Aldridge J, Becker S. Punishing children for caring: the hidden cost of young carers. *Children and Society* 1993;7:376-87.
11 *Children Act 1989.* Section 17(1).
12 Aldridge J, Becker S. Children who care. *Childright* 1993;97:13-4.
13 Aldridge J, Becker S. Children as carers. *Arch Dis Child* 1993;69:459-62.

Suspected myocardial infarction and the GP

Give aspirin

Two papers in this week's journal amply demonstrate the failure of many general practitioners to follow the recommendations of the British Heart Foundation's working group on managing patients with myocardial infarction. Why do doctors and other health workers repeatedly fail to carry out what is widely understood to be best practice even when the scientific evidence is solid and guidelines have been established?[1] Is it that doctors value their clinical freedom too much or that you cannot teach old dogs new tricks? Impassioned defences of clinical freedom, however, often mask dangerous and inefficient practice. Management based on findings from epidemiological studies and clinical trials is surely the best way forward.[2]

In the first of two studies examining recent practice Michael Moher, general practitioner, and Neil Johnson, a research fellow from the Radcliffe Infirmary, Oxford, review general practitioners' management of patients with suspected myocardial infarction against the recommendations made by the working group (p 760).[3] Of 137 patients admitted to two district general hospitals with suspected myocardial infarction, only 26 had been given aspirin before admission. Those who were subsequently shown to have infarction (96 patients) were neither more nor less likely to have received aspirin. As reported in other parts of Britain, the authors found a median delay of about four hours to intravenous thrombolysis; they recommend that ambulance crews should give aspirin.

Suspecting that the low use of aspirin may result from doctors not carrying the drug in their bags, Moher and colleagues surveyed general practitioners in the Oxford

Regional Health Authority (p 761).[4] Only 40% carried aspirin.

The second study of drug use, by two hospital doctors, Hazel Wyllie and Francis Dunn, shows even poorer standards of care (p 760).[5] Of 133 patients referred to hospital by their general practitioners with a suspected myocardial infarction, half were found to have had an infarct. Only four patients with suspected infarcts (and no patient with definite infarct) had been given aspirin before admission. Many patients had been given inadequate analgesia—often by the intramuscular rather than the intravenous route.

This week's journal also includes guidelines updating those of the British Heart Foundation's working group of 1989 (p 767).[6] This revision has come from continuing uncertainties about management in cases of suspected myocardial infarction. The objective, as before, is to reduce the morbidity and mortality from myocardial infarction and to decrease the time between the onset of symptoms and treatment. It seems as though mass public education programmes have been disappointing, bringing no long term benefits in survival. What is known, however, is that one third of patients who have a heart attack have appreciable pre-existing cardiovascular disease. Thus shouldn't the relatives of patients with cardiac disease be made aware of the European Resuscitation Council's guidelines[7] and be taught the best way to call for help? Apparently, the anxiety this causes families is less than has been feared.

The working group's guidelines are clear and comprehensive, but how are they to be implemented? Guidelines are not self implementing, and simply publishing them or lecturing on them is not enough.[8] Too little attention has been paid to how doctors function and how to help them improve their performance.[9]

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1 Delamothe T. Wanted: guidelines that doctors will follow. *BMJ* 1993;307:218.
2 O'Dowd T, Wilson A. Set menus and clinical freedom. *BMJ* 1991;303:450.
3 Moher M, Johnson N. Use of aspirin by general practitioners in suspected acute myocardial infarction. *BMJ* 1994;308:760.
4 Moher M, Moher D, Havelock P. Survey of whether general practitioners carry aspirin in their doctor's bag. *BMJ* 1994;308:761-2.
5 Wyllie HR, Dunn FG. Prehospital opiate and aspirin administration in patients with suspected myocardial infarction. *BMJ* 1994;308:760-1.
6 Weston CFM, Penny WJ, Julian DG on behalf of the British Heart Foundation Working Group. Guidelines for the early management of patients with myocardial infarction. *BMJ* 1994;308: 767-71.
7 European Resuscitation Council Basic Life Support Working Group. Guidelines for basic life support. *BMJ* 1993;306:1587-9.
8 Grimshaw JM, Russell IT. Effect of clinical guidelines on medical practice: a systematic review of rigorous evaluations. *Lancet* 1993;342:1317-22.
9 Grol R. Implementing guidelines in general practice care. *Quality in Health Care* 1992;1:184.

What's happening to practice nursing?

Moves towards greater professionalism should be supported

Observers of general practice in the United Kingdom are quick to recognise the huge contribution practice nurses have made in recent years. In 1985, when Julian Tudor Hart described them as an underused resource, much of their work was concerned with relieving doctors of some of the simple tasks that doctors were keen to delegate.[1] Since then many nurses have extended their activities into the management of chronic disease[2-4] and disease prevention.[5]

The few comparisons between nurses' and doctors' technical excellence and acceptability to patients have mainly favoured nurses.[2,4,5] The celebrated Burlington randomised trial of nurse practitioners, using appropriateness of clinical activity as a process measure and health status as an outcome measure, showed that they performed as well as general practitioners.[6] In her account of nurses extending their role in the management of diabetic patients, Murphy reported a few patients at the end of the study specifically requesting nurses to take the leading role in their care and quoted one as saying, "The doctor does have the knowledge but when it comes to the practical the nurse has the practical."[4]

A recent national census of practice nurses from the University of York confirms the trend for nurses to be taking on an increasing range of tasks.[7] More than 80% of nurses are involved in clinics managing chronic diseases. A similar proportion reports giving advice on minor illnesses and more than 40% identify early signs of anxiety and depression.

Several factors are responsible for this change. Firstly, there is pressure from inside and outside general practice to take on more responsibility for managing common conditions. Secondly, the use of structured approaches to care has increased within general practice, enabling nurses to carry out high level delegated functions according to agreed guidelines. Indeed it is likely that the process of delegation has benefited practices by encouraging them to agree guidelines and take the first steps in organised care.

Thirdly, the financial structure of general practice in Britain which, in contrast with systems that rely on fees for items of service, makes employing practice nurses very nearly financially neutral. Finally, it was practice nursing's own status, which initially seemed to put it outside the official nursing organisation.

These factors enabled nurses to be employed at different levels of skill, to negotiate a mix of activities that suited them, and to expand their range of skill and activities at their own speed. At worst, they are at the mercy of their general practitioner employers, without any provision for further training and at a disadvantage when asked to undertake tasks for which they feel poorly equipped.

Lisbeth Hockey identified this dilemma in 1984, contrasting the benefits to nurses of "pliability" within practices with their insecurity and lack of guaranteed entitlement to continuing education.[8] This disadvantage seems to persist: the York survey reported that fewer than half the practice nurses had attended a course approved by one of the national nursing boards and that study days were not an automatic entitlement of the job.[7]

All this has been illustrated by events surrounding the health promotion part of the general practice contract. The authors of the 1990 contract wanted to encourage activity in this area. Some general practitioners devised imaginative arrays of health promotion clinics to take advantage of the generous financial incentives; many employed extra practice nurses to take on some of the additional work. This arrangement was not sustainable, and on 1 April last year the system was changed from the open ended one to one of setting targets, attainment of which would be rewarded. Unsurprisingly, some of the practice nurses previously