mental.[7] Children under 5 are particularly at risk of immersion because their increased mobility is not matched by an awareness of risk. Although older children are more able to recognise risk, they may not be sufficiently informed about particular hazards, such as dangerous undercurrents at the beach or submerged debris in rivers. While older children can and should be taught to swim, young children cannot be relied on to save themselves, despite dubious claims about the effectiveness of "drownproofing" classes for young children.[8]

Parental awareness of the risks of injury to children and parental supervision are vital components of child safety, as of course is a knowledge of first aid. But the fact that drownings continue despite widespread publicity campaigns confirms that extolling parents and the public at large to "be careful" or "always supervise your child" are of limited use. Indeed, they may serve only to attribute blame.[9,10] Realistically, parents cannot be vigilant all of the time, and it is during periods of parental distraction that children are most at risk of drowning. This suggests the need for secondary measures of protection against hazards.

Passive safety measures that require little or no action on the part of individual people underpin the current theory and practice of preventing injury.[11] Commonly, passive child safety entails separating the child from the hazard. This is particularly effective in preventing childhood drownings as areas of water can be identified and, where feasible, a barrier erected. Regulatory or legislative measures may be necessary to ensure universal coverage of hazards, particularly when they are on private property.

Common sense, supported by evidence,[12,13] shows that fences provide protection from drowning in domestic swimming pools. Such a barrier needs to separate the pool not only from neighbours and the street but also from the house—a four sided isolation fence—as over 90% of toddlers who drown in domestic swimming pools are either residents of the house or invited guests.[12] Maintaining pool fences and self closing gates to ensure that they remain an effective barrier must be a focus of preventive campaigns. This must be coupled with education regarding the dangers of propping open the gate or allowing young children to swim unsupervised.[14]

Several state governments in Australia have recently debated legislation requiring four sided isolation fencing. This has been a contentious issue, with health professionals urging legislation to ensure the provision of safe environments for children. Opponents have argued from a civil libertarian platform, decrying laws that affect their own backyards as draconian and an infringement of their rights. Some even claim that legislation for child safety is ineffective, that parental supervision is the only preventive option. But the success of past legislation for child restraints in motor vehicles, bicycle helmets, and numerous safety requirements embodied in building codes and product safety standards attests to the appropriateness of regulatory requirements for safety, whether on the roads, in the home, or in the backyard. In addition, community expects government intervention to ensure that children are safe from both intentional injuries, such as child abuse, and unintentional injuries, such as drowning.

VICTOR F CAREY
Director

Childsafe NSW Injury Surveillance Unit,
Children's Hospital,
Camperdown,
New South Wales 2050,
Australia

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Maternal "near miss" reports?

Difficulties in defining which cases to include

Maternal mortality in the United Kingdom has now stabilised at around 7 per 100 000 maternities (defined as pregnancy and up to 42 days post partum). Sixty years ago it was 400 per 100 000, and its dramatic reduction has been a remarkable achievement.[1] Although better maternal health played a part, the fall was due not so much to socioeconomic factors as to improved maternity care in its widest sense.[1-3] Important contributions have been made by the Confidential Enquiries into Maternal Deaths.

Triennial reports on all maternal deaths in England and Wales began in 1952, and similar reports were issued in Northern Ireland from 1956 and in Scotland from 1965. Details about each case are collected on an anonymised form, which is reviewed by assessors in obstetrics, anaesthetics, and pathology and sent to a doctor at the Department of Health. A national panel of doctors classifies the cases according to cause of death and identifies avoidable factors. The forms are then destroyed. Obstetricians have learnt to trust this system, and, although the inquiry has no statutory powers, peer pressure ensures that collection is almost complete.

Because of falling numbers a single triennial report now covers all four countries in the United Kingdom.[4] This reduces the risk that specific cases might be recognised. But a more fundamental problem with small numbers is that the report might be based on unusual events of little relevance to most women's maternity care. The report's attention to individual cases contrasts sharply with the statistical approach used by large randomised trials, though the principle of auditing single events is being extended to perinatal and infant deaths[5,6] and to perioperative deaths.[7]

Might we obtain a more representative view of deficiencies in the maternity services by expanding the confidential inquiries to include "near misses?" Calls for research into medical accidents are increasing,[8] and "critical incident"

reporting has been introduced into other specialties.[9] In one intensive therapy unit, for example, staff are encouraged to report mishaps that worry them: blank questionnaires left in the coffee lounge are completed anonymously, posted, and summarised before being considered by a panel of senior staff[10]—a scheme similar to that of the confidential inquiries.

A major problem in extending the confidential inquiries would be difficulty in defining which cases to include. Accurate figures for maternal mortality are important indices of health care.[11] The diagnosis of maternal death is clear, numbers can be cross checked, and in Scotland reference to death certificates ensures that reporting is complete. This precision is one of the strengths of the inquiries.

The critical incident technique, by contrast, "makes no claims whatever for being able to detect the absolute incidence of anything."[10] Good obstetric units might detect near misses more rigorously than poor ones, and hospitals most in need of scrutiny might be the least vigilant. Defining non-fatal cases has been a problem for the National Confidential Enquiry into Perioperative Deaths, which had hoped to include "survivor cases" for comparison but so far has been unable to select them.[7]

Widening the inquiries into maternal mortality would mean a much bigger workload. More assessors could be appointed, but there would be an increased burden on obstetricians, who are already a heavily audited species.[12] Obstetricians' motivation to cooperate with the confidential inquiries has remained strong for 40 years but might weaken if the inquiries' status was reduced to that of a less focused audit.

Paradoxically, a widened report might lose much of its impact. The 1985-7 report, which examined the deaths of 265 young women,[3] could not lightly be dismissed as scare-mongering, but the inclusion of critical incidents might lead to a belief among the public that doctors are shroud waving—an accusation often levelled at today's obstetricians. The input of the pathologists lends gravity to the reports as well as diagnostic accuracy.

The United Kingdom confidential inquiries are important internationally. In many countries, particularly those with high female illiteracy rates,[13] maternal mortality is still at the level of Britain's in 1935. The World Health Organisation's safe motherhood programme is trying to persuade developing countries to improve maternity care,[14] and some are now introducing confidential inquiries, using the United Kingdom inquiries as their model. It would be unhelpful to move the benchmark.

Even in modern Britain women still die needlessly during and after pregnancy. As political pressure grows for change in the management of childbirth it is important to scrutinise mortality in case such changes compromise safety. The role of midwives is increasing, and the confidential inquiries' panel of assessors should now include a midwife. New audits of obstetric accidents should be introduced,[15] but they should be separate from the confidential inquiries. There are, sadly, still lessons to be learnt from the deaths of pregnant women in Britain, and one lesson is to beware of complacency.

JAMES OWEN DRIFE
Professor of obstetrics and gynaecology

General Infirmary,
Leeds LS2 9NS

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Giftedness

Parents and schools should provide for gifted children

The main sign of giftedness is precocity. Young people are regarded as gifted when they show intellectual, artistic, or motor behaviour characteristic of people several years older. Their precocious development might be in linguistic, logical mathematical, spatial, bodily kinesthetic, musical, interpersonal, or intrapersonal intelligence or ability, as delineated by Gardner,[1] or in analytical, synthetic, or practical intelligence, as defined by Sternberg.[2] Precocity and intellectual prowess may be the basic signs of giftedness, but many lists have been published of other characteristics of gifted children.[3,4]

Tannenbaum suggested that giftedness in childhood should be viewed purely as potential for development. He argued that the complex called "giftedness" consisted of five features: superior general intellect, specific talents or aptitudes, a set of non-intellective traits, a challenging and facilitative environment, and good luck at crucial times in life.[5] Dweck and Leggett also suggested that it was preferable for a child and parents to see giftedness as incremental or emergent rather than as an entity already possessed.[6] Such an attitude leads to the child being better motivated to learn and develop his or her talents.

Gifted children have special needs.[7] Those most commonly identified are, firstly, that the curriculum and instruction should be set at an appropriately challenging pace, level, and richness to facilitate academic growth and sustain motivation to learn. Secondly, gifted children need supportive and nurturing parents, teachers, peers, and mentors who help them develop long term goals and self esteem. And, thirdly, they need to understand their special talents, aptitudes, and personal characteristics and develop a capacity for self direction. Unfortunately, the schooling given to gifted children is often unsatisfactory and unproductive. Kroll and I found that gifted children are often bored at school—partly because of the low level and slow pace of the instruction and partly from having to spend much time being taught what they already know.[8] Gross and I documented the inappropriate handling of gifted children in school as well as the occasional