Saturday 1 March 1997

BMJ

Bringing nurses and doctors closer together

Greater cooperation will benefit patients

See pp 661, 682

High quality health care depends crucially on doctors and nurses working well together.[1] And every day throughout the world they do. Yet centuries after the professions of nursing and medicine were founded they remain curiously apart.[1-3] Doctors and nurses train separately, keep separate patient records,[4] report to different hierarchies, read different journals, and use different jargon. Sometimes these differences result in misery and conflict.[1-6] The *BMJ* and the *Nursing Standard*, for instance, recently described the sad case of a nurse who was suspended after cooperating with a doctor over the management of a disturbed elderly patient.[6 7] The professions and, most importantly, patients stand to benefit from closer cooperation,[1 3 8] particularly as nurses take on more work that has traditionally been undertaken by doctors.

Nursing is currently experiencing an intense debate over its future.[9] Throughout this century first doctors and then strong nursing theorists and leaders have shaped professional and public thinking about nursing. Now nurses agree that the art of nursing needs to be underpinned by a foundation in science. That scientific foundation is being built, and nursing is emerging as a scientific discipline that is distinct from but complementary to medicine. Politicians, however, increasingly see nurses as the lower part of a medical pyramid of knowledge and skills. This is unhelpful and wrong. If we treat nurses as "minidoctors" then patients will lose the enormous benefits that only nurses can offer.

There are, of course, important areas of overlap between the professions, and Terence English, a former president of the Royal College of Surgeons, delivered the Dame Kathleen Raven lecture on this subject at the Royal College of Nursing.[10] On page 661 he describes how nurses have taken on some tasks previously done by doctors.[11] His experience with the team in Cambridge performing heart transplantation taught him how important it is for nurses, doctors, and other health professionals to work still more closely together. But it also taught him the difficulties. He warns that "unless there is dialogue and trust between the groups, one or more of them are likely to feel threatened as their roles are changed." One way in which doctors and nurses will come to understand each other is through receiving some of their training together and understanding more of each others' roles from the start of professional training. On page 682 two medical students describe how much they learnt from a week working as nurses.[12]

As a contribution to encouraging closer cooperation among nurses and doctors, the Royal College of Nursing and the BMJ Publishing Group are this week publishing a mini-issue of a new journal, *Evidence-Based Nursing*. The first full issue will be published in November 1997. The mini-issue will be launched at a conference on evidence based nursing organised by *Nursing Standard* and the Royal College of Nursing. The BMJ Publishing Group and the Royal College of Nursing have already cooperated over the journal *Quality in Health Care*, and those who seek to improve quality in health care learn quickly that little can be achieved unless all parts of the healthcare team work together.[8 13] They also learn that making that happen can be hard.

Those who shudder at the mention of evidence based medicine may feel still more threatened by evidence based nursing. Florence Nightingale complained in 1860 that "No man, not even a doctor, ever gives any other definition of what a nurse should be than this—'devoted and obedient.'"[14] Although this view is still heard today, it is hopelessly outdated. The editors of *Evidence-Based Nursing*—Nicky Cullum, Alba DiCenso, and Donna Chiliska—describe in the mini-issue how they perceive the nurse of the next millennium[15]: "We expect nurses to care with their hearts and minds; identify patients' actual and potential health problems; and develop research based strategies to prevent, ameliorate, and comfort. We increasingly expect them to undertake work historically done by doctors; we also expect them to be empathic communicators who are highly educated, critical thinkers, and abreast of all the important research findings."

Evidence based nursing, just like evidence based medicine, is about combining clinical skills and experience with the best research evidence.[16] Much of what doctors do is not supported by good evidence, medical evidence is disorganised, and many doctors have difficulties finding and critically appraising research. For nurses, the problems are worse. Little evaluative research has been done on the outcomes of nursing care, and nurses experience many problems in accessing and appraising published research.[17] Yet a meta-analysis has shown that patients who receive research based nursing care have much better outcomes than those who receive routine nursing care.[18]

Evidence-Based Nursing will encourage research based practice. The journal will systematically screen nursing and medical journals to identify original papers and systematic reviews that are scientifically sound and carry a message that is important to nursing

practice. The journal will then publish an enhanced structured abstract of the paper together with a commentary that will appraise the new evidence and draw out its importance for practice. In addition, the journal will publish educational articles that will help nurses develop the skills necessary to practice evidence based nursing. We hope too that this joint publishing exercise will foster still greater cooperation between nurses and doctors, and better outcomes for patients.

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Tackling racism in the NHS

We need action not words

A BMA conference held last week to discuss racial discrimination in the medical profession highlighted a range of reports and publications written since 1987 that have documented the problem. Racial discrimination occurs at all levels in the medical profession, from applications to medical school,[1-3] through the examination process,[4] to job applications.[5 6] It also affects the manner in which complaints are made against doctors.[7 8] Our problem is not a lack of evidence but the lack of political will to tackle the problem.

That racial discrimination within the medical profession is widespread is a view many doctors may find hard to accept. But it is an accusation that must be taken seriously. With 23% of the medical workforce and, in some medical schools, 30% of the current intake classifying themselves as ethnic minorities, the issue is not necessarily one of under-representation of ethnic minorities but of equal opportunities—potentially affecting a quarter of doctors in Britain.

The problem of discrimination in the profession is first and foremost an ethical and moral issue, and, as a profession, we should be setting an example to society. The health service reflects society, but it is false to argue that we can make progress only if we solve society's problems first. The medical profession is an important leader of opinion in society—both at a national and local level[9] —and must take the lead in dealing with discrimination in its own ranks. As a profession, we tend to deny that there is a problem, and, with a few exceptions, our leaders have failed to make the fight against discrimination a top priority.

If research evidence has been available for many years, why has there been so little progress? The General Medical Council's ethical guidance for doctors[10] makes it clear that doctors must not themselves discriminate against patients or their colleagues on racial grounds. The council's president, Sir Donald Irvine, argued at the BMA conference that, as a profession, we have sometimes concentrated our efforts on quality standards for professional care and services to patients at the expense of considering the ethical context in which we deliver and practice our care.

The moral case against discrimination is surely unassailable. But there is a good business argument too. In a meritocracy we should not be arguing about the numbers of people from ethnic monitories applying for medical school or working in the profession but about equal opportunities to enter the profession and progress within it. The NHS loses if the best teachers, researchers, and clinicians are prevented from achieving their potential because of bigotry.

So what can be done? Recent legislation which removes the upper limit for compensation in cases where discrimination can be proved means that employers could face huge bills if found guilty. This will increase pressure on employers to ensure that they have systems in place that minimise the possibility of discrimination. It is no longer acceptable, for example, for consultants to shortlist and select junior doctors without following established guidelines on good personnel practices.

Applicants who feel they may have been discriminated against in job applications should be more willing to challenge the system using the established legislative framework. Unfortunately, most general practices, because they are classified as small businesses, are exempt from the provisions of the Race

See Career Focus in this week's classified advertising section

Basics of good practice in equal opportunities

- Applications should have all references to age, gender, and ethnicity removed before being assessed
- Shortlisting should be done using a standardised form (an example of which will be posted on the BMJ's web site)
- Interviews should follow a standardised objective format so that every candidate is asked the same questions and answers can be graded objectively

Relations Act; the professions' leaders should take a lead in arguing for this anomaly to be corrected.

Huge amounts of data are currently collected for ethnic monitoring of admissions to medical schools, job applications, and complaints against doctors, but existing processes fail to make these data available for public scrutiny and research. More openness and transparency is essential. The Council of Deans for Britain's medical schools could take a lead by making available existing data on the ethnicity of applicants to medical schools so that researchers can compare schools and the effects that their admissions policies have on ethnic minorities.

The General Medical Council should publish on a regular basis the outcome of complaints against doctors, by ethnicity, the number investigated, and the number eventually brought before its professional conduct committee. The NHS Executive should make it a management objective for chief executives of trusts and health authorities to monitor personnel practices so that poor practice is highlighted and acted on.

The *BMJ* also has its part to play. In its launch edition, Career Focus (carried each week in the classified advertising section) promised "to shine a light amidst the darkness of rumour, gossip, and individual preferment that so often characterises doctors' current experience of career advancement in Britain today."[11] Openness, transparency, and review of employment practice are the tools with which we will begin to tackle the serious injustice and waste that racism represents. With Career Focus, the *BMJ* dedicates two pages each week to publishing the best available information on how doctors can develop their careers. We look forward to using this space to disseminate good practice in equal opportunities; but we will also publish the experiences of those who have not been so fortunate. What is required in this European Year Against Racism is fewer excuses and a lot more action.

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Amiodarone pulmonary toxicity

Dose and duration of treatment are not the only determinants of toxicity

Amiodarone is an effective antiarrhythmic drug that was originally developed as an antianginal agent because of its vasodilator actions. Nowadays it is mostly used to treat patients with severe cardiomyopathy or coronary artery disease complicated by disturbances in the supraventricular or ventricular rhythm.[1 2] The therapeutic value of amiodarone is undisputed, but some doctors are reluctant to prescribe it because of its many side effects. These include impairment of liver and thyroid function and, rarely, damage to the lungs.[3] To avoid these hazardous adverse effects the recommended maintenance dose of amiodarone has recently been reduced to 200 mg a day.[4]

The clinical features of amiodarone pulmonary toxicity may not be recognised immediately, and even when suspected the diagnosis is often difficult to establish in patients with cardiomyopathy or serious coronary artery disease who present with non-specific symptoms and findings. The differential diagnosis may include cardiac failure, pneumonia, and pulmonary embolism. Suspicion should be heightened in patients whose daily dose of amiodarone has been more than 400 mg for more than two months or in whom a low dose has been given for more than two years.[5] However, we would stress that "amiodarone lung" may also appear during treatment at a low dose and for a short duration. This is most likely in patients at high risk because they are over 70 years old and have reduced functional capacity in several organs or a pre-existing lung disorder.

Amiodarone pulmonary toxicity, first described by Rotmensch in 1980, was initially thought to develop in 5-10% of patients and sometimes to be fatal.[6] More recent studies of the drug in patients with heart failure and patients recovering from myocardial infarction have found no pulmonary toxicity.[2] The explanation

seems to be that pulmonary toxicity from the drug is multifactorial.[7]

Amiodarone and its metabolites can damage lung tissue indirectly by immunological reactions or directly by a cytotoxic process. In patients with undoubted amiodarone pulmonary toxicity cytotoxic T cells have been found in the bronchoalveolar lavage fluid, often in combination with polymorphonuclear cells. Amiodarone influences the production of toxic oxygen radicals and may induce the accumulation of phospholipids in the tissues with a direct cytotoxic effect on the alveolar-capillary membrane in the lung. Though the risk of developing side effects rises with the plasma concentration of amiodarone,[8] there is no concentration at which it is inevitable. The risk of amiodarone pulmonary toxicity correlates better with the total cumulative dose[9] than with the daily dose and plasma concentrations.[3]

Patients who have developed amiodarone lung usually present with non-specific symptoms such as cough, dyspnoea, fever, and loss of weight. These symptoms may be mistaken for, or obscured by, symptoms of overt cardiac failure in a patient who is critically ill. The features of amiodarone pulmonary toxicity may emerge only after the underlying cardiac or pulmonary disease has been treated,[10] and this delay may increase the risk of a fatal course. The clinical diagnosis may be supported by radiological signs (hyperinflation or a ground glass or reticular pattern), by lung function tests (showing an obstructive pattern but sometimes a mixed or restrictive picture), and by histological findings. Bronchoalveolar lavage and lung biopsy will rule out malignancy or infection. There is, however, usually an increase in the number of lymphocytes, polymorphonuclear cells, and "foamy" macrophages. The presence of lamellar inclusion bodies is a specific histopathological finding associated with the cytotoxicity of amiodarone.

The differential diagnosis of amiodarone pulmonary toxicity includes several other infiltrative pulmonary disorders. These include bronchiolitis obliterans, bronchiolitis obliterans organising pneumonia, chronic eosinophilic pneumonia, and interstitial pneumonitis. Bronchiolitis obliterans organising pneumonia—a pathological entity characterised by destruction of the small airways by non-specific inflammation—is sometimes associated with amiodarone treatment. It runs a more benign course and has a better therapeutic response to corticosteroids than the other infiltrative pulmonary diseases.[11 12]

We have already mentioned the complex relation between dose of amiodarone and toxicity. Doctors often assume that pulmonary toxicity occurs only when high doses of amiodarone are used for a long time, but in practice a low maintenance dose (<300 mg) of amiodarone may also be toxic.[13] The picture is complicated further by reports of an early incidence of amiodarone pulmonary toxicity in the first 12 months after the start of treatment even at a low dose.[5] The increased risk in elderly patients with damaged lungs[6] may be partly explained by a reduced volume of functioning lung tissue being exposed to a higher than predicted tissue concentration of the drug.[14]

Once amiodarone pulmonary toxicity has been detected several options are available. Firstly, treatment may be stopped—with the risk of a recurrence of life threatening arrhythmia. This risk can be reduced by substituting another suitable antiarrhythmic drug. Secondly, amiodarone may be withheld for several days and the dose then reduced to the lowest effective level. The third choice is to consider non-pharmacological (and expensive) treatments such as radiofrequency ablation of the causative re-entry mechanism or implantation of an automatic cardioverter defibrillator.

Even when amiodarone is discontinued the toxic effect may persist because of the long half life (up to 45 days). The value of treatment with corticosteroids is uncertain, with the exception that early treatment of bronchiolitis obliterans organising pneumonia with steroids is effective in more than 60% of subacute episodes. In general, at least six months of maintenance treatment is recommended because of the chance of relapse.

In conclusion, amiodarone pulmonary toxicity is a potentially fatal and complex disease that may easily be masked by pre-existing cardiopulmonary disorders. On the other hand the very presence of underlying lung disease may enhance the pulmonary toxicity of amiodarone even at low doses. The cumulative influence of other risk factors such as impairment of liver or renal function must be evaluated for each patient. Clinicians should be alert to the possibility of amiodarone pulmonary toxicity regardless of the dose and duration of treatment, especially in elderly patients with damaged lungs. Early diagnosis is crucial since the pulmonary toxicity is reversible, especially when it takes the forms of bronchiolitis obliterans and bronchiolitis obliterans organising pneumonia.

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The coming of age of sports medicine

Growing demand must be matched by specialist accreditation and recognition

Recent proposals are set to change the way sports medicine is perceived and practised in Britain. Sports medicine is not new but has been practised away from mainstream medicine as a hobby or in the domains of private practice and physiotherapy. There has been no formal accreditation or recognition of the specialty and little or no provision for sports medicine within the NHS. Its Cinderella status in Britain reflects the struggles of an emerging discipline within the confines of the traditional medical paradigm. But this position is not universal. Other countries have successfully produced models of education and practice of sports medicine to suit their own healthcare systems.

The term sports medicine is emotive as it has connotations of care limited to the sporting elite. This is wrong. More accurately described as sport and exercise medicine, the specialty covers the entire spectrum of human performance and reflects the total medical care of people who exercise.[1] The continuum of care ranges from high level athletes seeking to optimise their performance to people exercising to aid recovery after physical and psychological illness or injury. These populations typically receive uncoordinated, inconsistent, and regionally variable care, providing a strong case for making primary care a cornerstone of this emerging specialty. This argument is strengthened by the numerically largest group of exercisers—the population at large exercising for health.

There are many reasons why the development of sports medicine has failed to progress in Britain. Specifically, there has been no single respected voice to coordinate education, research, service provision, and accreditation. Britain is now behind North America, Australasia, the Far East, and much of Europe, where accreditation systems have emerged with specialist recognition. In the United States, four boards of primary care specialties (emergency medicine, family medicine, internal medicine, and paediatrics) offer a certificate of added qualification in sports medicine on the basis of a written examination.

Canada, with its Royal medical college, has a medical system more analogous to Britain's. The Canadian Academy of Sports Medicine has taken on the role of academic development through its journal and the development of a diploma examination. However, despite an organised and expanding educational fellowship system for sports medicine, the academy has yet to receive specialist recognition from the Royal College of Physicians and Surgeons of Canada.[1]

In Australia specialist recognition is on its way after the establishment of the Australian College of Sports Physicians in 1985. The college's primary aims are establishing curricula and setting standards through examination and supervision of training programmes. Their fellowship examination is in two parts separated by three years of dedicated fellowship training.

Similar systems of training and accreditation exist with specialist accreditation in five European countries. In Finland, where specialist recognition occurred in 1986, training posts in sports medicine exist with emphasis on research and the health benefits of exercise. In the Netherlands, specialist recognition arrived in 1987, based on a four year training scheme. Considerable importance is placed on the public health aspects of sport and exercise, and registration occurs under a category of social and preventive medicine.

Britain is entering a critical phase in the development and recognition of sport and exercise medicine. We now need a process of accreditation and specialist recognition. This will require an intercollegiate board for sport and exercise medicine to be established under the auspices of the Academy of Medical Royal Colleges. The board should be accountable to the medical Royal colleges, and its constitution should allow curricular development, examination, and accreditation, with an initial emphasis in primary care. Parallel development of higher specialist training as a subspecialty year for other medical or surgical specialties and a full programme for primary care should be developed, with the award of a certificate of completion of specialist training consistent with the Calman recommendations. As has happened in the United States, subsequent development of the undergraduate medical curriculum should reflect the growing interest in this aspect of medical practice.[2]

The government has raised the profile of sports medicine through its encouragement of sport for health and the development of a British Academy of Sport.[3,4] The BMA, through its publication *Sport and Exercise Medicine: Policy and Provision*, has widely endorsed these views and set out clear recommendations for the development of sport and exercise medicine.[5] Sport and exercise medicine should now be recognised as a specialty based on the relevant basic sciences and clinical practice. Much of the educational programme exists, and the time is right for accreditation and the development of independently assessed training programmes, established on the basis of similar developments in other fields of clinical practice.

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Childhood matters

Doctors have a vital role in identifying children at risk of abuse

See p 677

Britain is failing too many of its children. This is the bleak conclusion of the recently published report of the National Commission of Inquiry into the Prevention of Child Abuse (*Childhood Matters*).[1] At some time, 10% of children are at risk of substantial harm. This could be prevented, and, rightly, few agencies or professional groups are spared the requirement to improve.

The commission defines child abuse as "anything which individuals, institutions or processes do or fail to do which directly or indirectly harms children or damages their prospects of a safe and healthy development into adulthood." Hence, the omissions of our professions and our tardiness in implementing change, from this perspective, are themselves abusive. This has already attracted criticism from the government, the key institution with parent-like responsibilities, which is presently considering a return to more brutal methods of child rearing.[2]

Evidence was taken from over 10 000 people, including many who were abused as children. Despite greater attention to abuse in the past decade, children continue to be abused, usually by their carers, family members, or acquaintances. At least half of this abuse is not disclosed when it occurs. In most instances it is preventable since it is known, or strongly suspected, by a third party. Our systems frequently fail to prevent abuse from occurring or fail to recognise it at an early stage. Services respond when serious abuse is identified, at a cost of about £1bn ($1.6bn) a year. An expensive court system presides over the selected cases that reach it, unintentionally adding further damage to children and families. Children still fall through the net of agencies and local and national government structures.

The goal of any civilised society must be to prevent child abuse. So how do we achieve this? The commission recognises that there is little evidence of what works or is cost effective. However, new ways must be sought within our existing knowledge of the causes and consequences of abuse, while further research is undertaken. Over four million of the country's 13 million children live in families receiving less than half the average national income. Poverty damages children's lives, and, when linked to other factors such as poor housing and diet, stress builds up and abuse often follows.

Perhaps too much emphasis is given to investigating suspected cases of abuse at the expense of supporting families.[3] The Children Act (1989) created a welcome shift in emphasis in the way professionals work with parents[4]; however, it fails to address the welfare needs of the large group of "children in need," including those facing poverty, disadvantage, and social disruption. Simply redistributing limited resources from child protection to family support would leave more children unprotected. New resources are needed.

Additional resources for social work training, improved handling of court cases, and a curb on increasing bureaucracy would help. There are over 80 specific recommendations in this 380 page report. Many reflect the need to give higher national priority to the issue of children's welfare. In government, children should be represented by a secretary or minister of state with enhanced ministerial responsibility for children. Close to the centre of government, a high profile children's commissioner, as exists in some other countries, would be a tangible expression of the will to address children's interests.

Other recommendations underline the need to educate for parenting, to create child friendly communities, and to emphasise the fact that children are not possessions but individuals with rights and developing responsibilities. The commission calls for improved statistical information on the state of Britain's children, including more information about abuse; (there are fewer statistics than 10 years ago). Other recommended changes involve new legislation; improvement in the operation of current law; greater integration between social services, education, and health authorities; and improved regulation of staff who work with children to provide better safeguards. Children should receive the same protection as adults, which would mean removing from the statute book the defence of "reasonable chastisement."

Those commissioning and providing health services should give greater emphasis to preventing neglect and abuse. The importance given in this report to the general practitioner's role in identifying children at risk from abuse makes a sharp contrast to the BMA's *Core Services: Taking the Initiative*, which fails explicitly to mention it among general practitioners' core responsibilities.[5]

The commission's findings must be welcomed and supported as a way to move forward in thinking and practice about children's welfare. Greater public involvement is required. Child abuse is everybody's responsibility not just that of professionals. We may give lip service to the importance of childhood; this must be converted into practical action. Only by action will we really demonstrate that childhood matters.

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