in scientific journals and maintain that these influence editorial policy (p 798).¹³ Scientific journals are more likely to advance psychiatric explanations for symptoms than the lay press (p 776).¹⁴

The findings reported in this week's journal should help doctors deal with the main source of the controversy about fatigue states—whether chronic fatigue syndrome is a physical or mental illness. We find this semantically difficult to discuss because we do not accept the distinction between physical and psychological medicine that pervades the medical literature and that is even more evident in pamphlets from self help organisations.^{15,16} Clearly, however, in some patients labelled as having chronic fatigue syndrome or myalgic encephalomyelitis, psychiatric diagnoses—with all their faults and problems—would improve management. Given the strength of the association with psychiatric morbidity, it is mandatory that doctors explore this dimension in all patients with syndromes of chronic fatigue. If, in turn, patients suggest that this approach implies that they are not genuinely ill, the findings of Wilson *et al* can be used to show just how much suffering and disability is associated with psychiatric disorder.¹¹

What about the psychological attributes that are strongly associated with poor outcome? Wilson *et al* point out that a conviction of physical disease may arise from severe physical symptoms, but the possibility that a strong belief in a physical—usually viral—aetiology may actually cause prolonged and preventable disability cannot be ignored.¹¹ This “physical conviction” and “psychosocial denial” may promote chronicity if a virus becomes seen as the source of all problems and encourages patients to avoid dealing with personal difficulties.¹¹ Indeed, if an illness is attributed entirely to external sources there will be little scope for self help. One thing is clear. Although the outcome for the Australian patients was disappointing, this and other follow up investigations^{17,18} can be used to challenge the nihilistic prognoses given by some myalgic encephalomyelitis associations and doctors that, for example, “most of the cases seen do not improve, give up their work, and become permanent invalids.”¹³

Myalgic encephalomyelitis was originally described as benign.¹⁹ Recovery from syndromes of chronic fatigue has

now been shown to be independent of virology¹⁷ and immunological measures, and a poor outcome to be related to psychological morbidity.^{11,18,20} The worst outcomes are reported by those who view the condition as of entirely physical (infectious) aetiology and advocate complete rest.^{3,15} Results of randomised controlled trials examining whether these attitudes can be modified by talking treatments and whether this improves outcome are eagerly awaited. In the meantime, doctors can use this week's scientific findings to improve clinical care of their patients with chronic fatigue.

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Who cares for young carers?

Their invisibility is the first problem to be addressed

How much do we know of young carers—that is, children under 18 who provide primary care for sick, disabled, or elderly relatives in the home, usually their own parents?¹ Meredith suggested that health professionals have failed to identify such children and have shown interest in them only when the possibility of psychological or physical disorders has been raised.²

Small studies have suggested that there are at least 10 000 young carers in Britain.^{3,4} Recent research has, however, rejected the usefulness of such data, concentrating instead on the qualitative impact that caring may have on a child's health, psychosocial development, and opportunities.⁵⁻⁷

A substantial obstacle to addressing the needs and concerns of young carers has been a lack of awareness of their existence. Providers of services—whether health, education, or social services—have consistently failed to identify young carers. As

one young carer said, “You can't picture a child picking up an adult, getting them on to the stair lift, taking them up, bathing them. If you can't picture it, it doesn't happen.”⁸

Bilsborrow refers to the “gradual recall” by informants in care agencies of young carers, both past and present, but only after the informants had initially denied any knowledge of young carers among their caseload.⁸ Interest was obviously focused so specifically on the receiver of care that the needs and circumstances of the giver of care went unrecognised.

Young carers are often reluctant to identify themselves or to make known how much caring they do for fear of professional intervention. They tend to view social workers with suspicion—and not without reason. For, as Meredith pointed out, “It is apparent that the option of care proceedings [leading to institutionalised care, either for the child or for the person receiving care] is used, or threatened, much too early.”⁹

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 Becker⁵—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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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? 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