approach. Case finding, notification of cases, enhanced surveillance, and modification of the environment in which the disease exists are strategies that can usefully be applied to bullying. Doctors are perhaps better placed than parents to push this approach.

We need also to recruit the vast majority of children who are neither bullies nor victims. In my survey of a secondary school in Nottingham the response of three quarters of children to the bullying of another child was that of a bystander who does not want to get involved; a fifth said they could be persuaded to join in (unpublished data). Whitney and Smith found that most children did nothing to help victims either because they did not know how to help or because they thought it was not their business.² Perhaps this statistic would make a good indicator of the success of an anti-bullying programme. Children should be taught not only not to bully others but also not to tolerate bullying of others.

Health care staff working with children in the primary care setting have a vested interest in working in concert with school authorities towards this ideal: they will have less morbidity related to bullying to deal with. One approach would be to regard the detection of a case of bullying as an indication of serious problems in the interrelationships of children in the school. As in established child protection procedures, a case conference should be called of all professionals concerned and a strategy agreed for the prevention of future cases.

VIDYA RAO

Lecturer in community child health

Department of Child Health,
Faculty of Medicine,
University of Nottingham,
Queen's Medical Centre,
Nottingham NG7 2UH

1 Dawkins J. Bullying in schools: doctors' responsibilities. *BMJ* 1995;310:274-5. (4 February.)

2 Whitney I, Smith PK. A survey of the nature and extent of bullying in junior/middle and secondary schools. *Educational Research* 1993;35:3-25.

Accident and emergency departments need management guidelines

EDITOR,—Judith Dawkins emphasises the importance of doctors' recognition of bullying.¹ Accident and emergency departments may be one point of contact between health care services and child victims of bullying. We reviewed the case notes of 305 children presenting to an urban accident and emergency department in the west of Scotland because of incidents at school over 56 weeks in 1993 and 1994. Twenty of the children had attended because of injuries deliberately inflicted by others.

Twelve of the children were boys and eight girls; the group was equally divided between primary and secondary schools. The child had been tripped or pushed in 10 cases, punched or kicked in three, and intentionally struck on the head or face by a brick or stone in three. One child attended after taking a drug overdose after an assault at school. Two further episodes resulted in serious injuries, with one child sustaining a facial fracture after being struck by a baseball bat and another receiving multiple injuries after falling 15 m while trying to escape from pursuers. In total, the children sustained six fractures, required 23 inpatient days of treatment, and received two general anaesthetics during their treatment. The group made 18 attendances at the fracture clinic.

These cases were identified during work designed to find the health care needs associated with accidents at school. The project did not attempt to collect information specifically on bullying, and the figures are therefore likely to be underestimates of the true number of children presenting to accident and emergency departments as a result of bullying at school. The review of the

case notes showed that casualty officers recorded the mechanism of injury more often than they noted the cause of the incident.

We suggest that accident and emergency departments are an important point of contact with children who are victims of bullying. Training for staff should include information on recognising bullying and advice on what steps to take when it is identified. Assessment of children with injuries related to school should include direct questioning about the cause as well as the mechanism of injury. Closer liaison among education departments, hospitals, parents, and police when appropriate may offer great benefits to child victims of bullying.

JOHN WRIGHT

Senior house officer in surgery

Royal Alexandra Hospital,
Paisley PA2 9PL

CAMERON STARK

Consultant in public health medicine

Ayrshire and Arran Health Board,
Ayr KA7 4DW

1 Dawkins J. Bullying in schools: doctors' responsibilities. *BMJ* 1995;310:274-5. (4 February.)

Assessing the consequences of changing childbirth

General practitioners collect valuable data

EDITOR,—James Owen Drife's editorial on assessing the consequences of changing childbirth contains several valid points.¹ The historical basis of the collection of data by hospital units may well have resulted in high quality clinical audit. Regrettably, such data collection has invariably missed a major source of clinical data—namely, the data recorded by the general practitioner throughout the woman's antenatal and postnatal care. General practitioners have rarely been encouraged to share such data with other carers in the NHS. Maternity care is but one example of this. Diabetes, asthma, and rheumatoid arthritis are three major diseases in which most care is given in the primary care sector and yet decisions and national comparative analyses are based mainly on hospital records.

Changing Childbirth has highlighted the role of the primary care team in providing continuity of care.² It also recommends that mechanisms should be developed to ensure that data are made available for national analysis. Now, with the development of the Read code as a national standard for recording and sharing data within the NHS and the development of electronic links between practitioners and the family health services authorities and health boards, true national statistics should be possible. A further step, however, is required. General practitioners must be encouraged to understand the implications of recording data. All too often inadequate or inappropriate Read codes are used for morbidity data, with the result that data analysis becomes too generalised for appropriate conclusions to be reached.

The important issues raised in Drife's editorial should encourage family health services authorities or health boards to implement standards for the recording of morbidity in primary care. These organisations should also develop appropriate training in data analysis for primary care teams so that they can experience the benefits of the mass of data at their fingertips.

NIGEL HIGSON

General practitioner

Goodwood Court Surgery,
Hove BN3 3DX

1 Drife JO. Assessing the consequences of changing childbirth. *BMJ* 1995;310:144. (21 January.)

2 Department of Health. *Changing childbirth*. London: HMSO, 1993.

Time is ripe for a "pregnancy based system" of data collection

EDITOR,—James Owen Drife echoes the widespread anxiety regarding the inadequacy of present maternity data and emphasises the importance of satisfactory information for assessment of the consequences of changing practices of pregnancy care in Britain.¹ His proposal for an improvement in the collection of data is feasible, and the necessary building blocks for achieving this are already being put in place through the initiatives of the Information Management Group of the NHS Executive.

The NHS Executive launched the NHS information management and technology strategy in December 1992. One of the principal initiatives of the strategy is "a common [information management and technology] infrastructure for secure sharing of information."² Included in this initiative are the replacement of the NHS number, the development of NHS administrative registers, NHS-wide networking,³ a thesaurus of clinical terms, technical standards, and ensuring confidentiality and security. These projects are well under way, and some are nearing completion. An NHS number with a new format will be introduced this year to replace the diverse formats (more than 20) that exist now. NHS-wide networking will allow family health services authorities, regional health authorities, district health authorities, general practitioners, community carers, hospitals, and others to communicate with each other and share information subject to security and confidentiality safeguards. The aim of the "terms project" is to produce Read terms version 3, which will be a national thesaurus of agreed clinical terms. The medical component of the thesaurus has already been launched after the participation of over 1000 clinicians from 43 medical specialty groups. The full version 3, with contributions from professions allied to medicine (chiropody and podiatry, dietetics, occupational therapy, physiotherapy, and speech and language therapy) and the nursing professions (health visitors, midwives, and nurses), is scheduled to be ready by July.

Hence the infrastructure needed for the adequate collection of nationwide maternity data will soon be in place. The time is now ripe for the development of a standard "pregnancy based system,"¹ which will enable records not only of antenatal and intranatal care but also of postnatal care to be kept. The system will need the endorsement of all professional bodies involved with the care of pregnant women before its implementation can be planned.

ARABINDA SAHA

Research worker

Obstetrics and Gynaecology Specialty Working Group,
Clinical Terms Project,
Royal College of Obstetricians and Gynaecologists
Medical Audit Unit,
St Mary's Hospital,
Manchester M13 0JH

1 Drife JO. Assessing the consequences of changing childbirth. *BMJ* 1995;310:144. (21 January.)

2 Information Management Group. *This is the IMG: October 1994*. Leeds: NHS Executive, 1994.

3 Information Management Group. *IM&T strategy overview*. Leeds: Management Executive, 1992.

Smart cards are expensive and easily damaged

EDITOR,—James Owen Drife suggests that the pregnancy health record "Combined with a 'smart card'...could provide good pregnancy based data."¹ Those who have suffered in the struggle to domesticate the awesome power of the computer chip eventually learn, too often the hard way, three important things. (1) Always keep the master version in the safest place and ensure that it is frequently and regularly backed up. (2) Too often