Prognostic factor	Relative risk (95% confidence interval)	P value
Tumour thickness:		
> 1 mm v ≤ 1.00 mm	2.6 (1.8-3.8)	> 0.0001
> 2 mm v 1.01-2.00 mm	2.7 (2.2-3.4)	< 0.0001
< 4 mm v 4.01-4.00 mm	1.6 (1.4-2.0)	< 0.0001
Level of invasion:		
≥ III v II	4.0 (2.0-8.1)	< 0.0001
Sex:		
Male v female	1.5 (1.3-1.8)	< 0.0001
Anatomical location:		
TANS v non-TANS	1.6 (1.4-1.8)	< 0.0001
Histological subtype:		
ALM v SSM or LMM	1.7 (1.2-12.3)	< 0.01
NM v SSM or LMM	1.2 (1.0-1.4)	< 0.05
Age: [*]		
> 60 years v ≤ 60 years	1.2 (1.0-1.4)	0.05
Year of diagnosis [†]		NS
Safety margin:		
< 2 cm v ≥ 2 cm		NS

TANS=thorax, upper arm, neck, and scalp; ALM=acral lentiginous melanoma; SSM=superficial spreading melanoma; LMM=lentigo maligna melanoma; NM=nodular melanoma; NS=not significant. Results are adjusted for the effects of the participating centres.

*Classification of age: ≤ 30 years; 31-60 years; > 60 years.

†Classification of year of diagnosis: 1970-5; 1976-80; 1981-5; ≥ 1986.

confirmatory studies are needed, these data may allow physicians to provide more accurate information on survival to their patients with melanoma.

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Ethical Debate

Should doctors be more proactive as advocates for victims of violence?

Currently the management of adult victims of violence by general practitioners and accident and emergency departments is reactive, concerned almost exclusively with the management of physical injuries. Professor Jonathan Shepherd outlines some ideas for a more proactive approach on the part of doctors to improve the protection and support of vulnerable people; to deal with psychological sequelae; to take the responsibility of making an official complaint to the police away from seriously injured people, who are unable to give or withhold consent to disclosure; and to prevent assailants inflicting further injuries. We asked a sociologist, a psychiatrist, a moral philosopher, and a police surgeon for their comments.

Towards interagency procedures to protect victims and prevent violence

Jonathan Shepherd

A public health approach to violence has focused so far on risk factors such as alcohol consumption,¹ availability of firearms,² and links between deprivation and crime³ but has yet to include trying to bring violent offenders to justice. Yet there is now strong evidence of

a link between the incidence of violence and the rate at which offenders are convicted. Increasing the rate of conviction is therefore likely to be an effective way to prevent injury.

Criminal justice and public health have much in common. Both use deterrence (health warnings), incapacitation (isolation), and rehabilitation. A public health approach, however, focuses on the injured rather than the offenders. It can therefore be concerned with the very large number of violent incidents on both sides of the Atlantic that are neither reported to nor recorded by the police.^{4,7} In Britain only about a quarter of the assaults resulting in treatment at accident and emergency departments are recorded by the police.⁸

Although criminal law treats all assaults as offences against society, the initiation and maintenance of the prosecution process depends on the injured themselves.⁹ Many of these people are repeatedly injured by assailants in whose "web of power" they are trapped.^{5,9} This applies not just to women who are injured in domestic violence but to many other people.⁹ Many victims do not report violence or make complaints that trigger police action because they are incapacitated by their injuries, afraid of reprisals, habituated to violence, or have a continuing relationship with their assailants. Furthermore, because the police judge that many victims who report offences will drop the

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prosecution, investigations are often perfunctory or abandoned at an early stage.⁹ This results, in part, from the fact that the offender and the state are central in the criminal justice system and means that many of society's most vulnerable people are not being protected as they should be. People who are at the same time victims and patients are, however, central to health care. This means that doctors should be influential advocates for victims as part of a much wider, proactive, interagency approach in which psychological sequelae can also be recognised and dealt with.

When it is in the medical interests of victims (in relation to preventing future physical and psychological harm) health professionals should counsel them to report offences or to allow the health professionals to do so on their behalf.

There are dangers, however, in a closer relationship between the police and accident and emergency departments—in particular that victims of violence, who may themselves be on the edge of the law, might be dissuaded from seeking medical help. Nevertheless, the General Medical Council's current guidance, that each disclosure be considered individually, implies that the participation of other agencies should be considered when treating anyone injured in an assault. Violent offences should be reported to the police, without the patient's consent if necessary, if injury is very serious or if failure to disclose appropriate information would expose the patient or someone else to a risk of serious harm. When injuries are not serious and the victim does not wish to initiate a police investigation, making available anonymous details of violence could still help to prevent future crime. The collection of this information would be straightforward, particularly integrated with the recording of information already necessary for Criminal Injury Compensation Authority reports.

Organisations such as Crime Concern should include data on injury from accident and emergency departments in their assessments of urban violence, and department computers should be networked to facilitate annual reports on violence. Accident and emergency departments need to be more integrated with community policing. A crucially important barometer of civil order is the incidence of injury, but this is being ignored both locally and nationally. Apart from the valuable contribution of the charity Victim Support, few attempts have yet been made to bring together the disparate agencies responsible for the care and protection of injured adults. Many of them are young men.⁷ There is a need for a joint forum to

develop, monitor, and review policy based on a sound legal and ethical framework. Area child protection committees are a model, though terms of reference for adults would differ.

In relation to violence, the implications of a community approach are clear. Health care should be organised not only to provide treatment for people injured in assaults but to reduce the risks of further injury in the communities and families from which they come.

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The sociologist's view More convictions won't help victims of domestic violence

Rebecca Morley

Women victims of domestic violence constitute an unknown but undoubtedly substantial percentage of admissions to accident and emergency departments for injuries sustained through violence. Although the authoritative British crime surveys have shown consistently, for all violence, that men are more often victims than women, they have also shown that much domestic violence is not reported to the police. The 1992 survey showed that 80% of domestic violence was directed at women.¹

Medical records of women attending hospital emergency departments in the United States indicate that up to 25% have a clinical profile consistent with domestic violence, though few are identified as such by medical staff.^{2,3} An adequate approach to handling such admissions must accommodate the circumstances and needs of victims of domestic violence.

The underlying premise of Professor Shepherd's argument—that increasing rates of conviction is an effective way to prevent injury—is flawed in the case of domestic violence. North American research echoes more circumstantial evidence from Britain that criminal justice responses alone do not effectively deter offenders or protect victims, except sometimes in the very short term; indeed, without community supports to enable victims to protect themselves, arrest and prosecution may result in more severe violence from an angry assailant on release.^{4,5} Many women do not wish to take police action, not because they are habituated to violence⁶ but often because they fear reprisals or a coercive criminal justice response, or both. In some North American jurisdictions the number of calls to the police for help fell after mandatory arrest and prosecution policies were introduced.⁴ Integrating accident and emergency departments with community police in the way proposed by Professor Shepherd would almost certainly dissuade some women from

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Doctors should know about assessing trauma and referring patients for specialist help

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