finds sexual victims everywhere. False accusations of child sexual abuse do occur, particularly in the context of custody disputes, when one partner may consciously or unconsciously suggest, encourage, and shape the child's accusations. Until recently a great injustice was done to victims of child sexual abuse by ignoring their plight as children and attributing their accounts as adults to oedipal and incestuous fantasies. When panic about child sexual abuse produces witch hunts for child molesters there is a risk of replacing one form of injustice with another.

Clearly the immediate impact of child sexual abuse has the potential to produce behavioural and psychological problems.⁴ Studies of adults who report having been abused as children suggest increased rates of psychiatric disorders and sexual problems in adult life. Such evidence has been drawn from studies of groups of patients, self identified victims, and students and from community surveys employing random sampling techniques. The most powerful support for a correlation between child sexual abuse and later psychiatric disorders has come from studies of representative community samples using standardised psychiatric measures.⁵⁻⁹

People giving a history of child sexual abuse have increased rates of depressive disorders, anxiety disorders, and alcohol and drug abuse. Community studies suggest that the risks of victims of child sexual abuse developing mental disorders in adult life are increased two to 12 times.¹⁰ The rigorous studies are consistent in showing a strong, specific, and coherent association between child sexual abuse and long term psychiatric problems. The questions that remain are not whether there is such an association but about the mechanisms that mediate between that abuse and later disorder.

How, then, could West claim in a recent review that retrospective surveys of population samples of adult women have found no detectable long term effects in most of those who recall childhood sexual contacts with older people?¹¹ This is strictly correct if possibly misleading: there may be a substantial increase in psychopathology even if more than half

those sampled are unaffected. Drunk drivers don't always have accidents and only occasionally kill and maim, but who would counsel greater acceptance of such behaviour on this basis?

The level of child sexual abuse in our societies is a scandal, and the educational, health, and justice services should be making efforts to reduce it. Most men who use children for sexual purposes are not violent or sadistic; though sometimes insensitive and brutal, they are often inadequate people with limited capacities for emotional and sexual expression. Though their stunted development may evoke sympathy, their acts cannot be regarded as other than damaging and potentially dangerous to children. Doctors need to be alert to the possibilities of child sexual abuse, both in children and as a contributing factor to a wide range of psychiatric and social problems in adult life.

PAUL E MULLEN

Professor of Psychological Medicine,
University of Otago Medical School,
PO Box 913,
Dunedin,
New Zealand

- 1 Finkelhor D, Hotaling G, Lewis IA, Smith C. Sexual abuse in a national survey of adult men and women: prevalence characteristics and risk factors. *Child Abuse Negl* 1990;14:19-28.
- 2 Siegel JM, Sorenson SB, Golding JM, Burman MA, Stein JA. The prevalence of childhood sexual assault. *Am J Epidemiol* 1987;126:1141-53.
- 3 Li CK, West DJ, Woodhouse TP. *Children's sexual encounters with adults*. London: Duckworth, 1990.
- 4 Finkelhor D. *A sourcebook on child sexual abuse*. Beverley Hills, California: Sage Publications, 1986.
- 5 Bagley C, Ramsay R. Sexual abuse in childhood: psychological outcomes and implications for social work practice. *Journal of Social Work and Human Sexuality* 1986;4:33-47.
- 6 Mullen PE, Romans-Clarkson SE, Walton VA, Herbison GP. Impact of sexual and physical abuse on women's mental health. *Lancet* 1988;i:841-5.
- 7 Stein JA, Golding JM, Siegel JM, Burnam MA, Sorenson SB. Long-term psychological sequelae of child sexual abuse: the Los Angeles epidemiologic catchment area study. In: Wyatt GW, Powell GJ, eds. *Lasting effects of child sexual abuse*. Beverley Hills, California: Sage Publications, 1988:135-54.
- 8 Peters SD. Child sexual abuse and later psychological problems. In: Wyatt GE, Powell GJ, eds. *Lasting effects of child sexual abuse*. Beverley Hills, California: Sage Publications, 1988:107-17.
- 9 Winfield I, George LK, Swartz M, Blazer DG. Sexual assault and psychiatric disorders among a community sample of women. *Am J Psychiatry* 1990;147:335-41.
- 10 Mullen PE. The long-term influence of sexual assault on the mental health of victims. *J Forensic Psychiatry* 1990;1:13-34.
- 11 West DJ. Incest in childhood and adolescents: long-term effects and therapy. *Br J Hosp Med* 1988;40:352-60.

What now for IPPNW?

Must extend its mission to global security

International Physicians for the Prevention of Nuclear War (IPPNW) must be one of the most successful medical organisations ever. Established in 1981, it won the Nobel prize for peace in 1985, grew rapidly to include over 200 000 million doctors from almost all countries of the world, and played an important part in dramatically reducing the chance of nuclear war. Now it is in crisis, the victim of its own success. The collapse of the iron curtain has reduced concern about nuclear war. The issue most concerning delegates at last month's meeting of IPPNW in Stockholm was whether the organisation has a future and if so what it is.

Various ingredients have come together to make IPPNW so successful. Most important have been the clarity, focus, and importance of its mission—to abolish the possibility of nuclear war and rid the world of nuclear weapons. This is a mission that all doctors—from east and west, north and south—can subscribe to. Nuclear war threatens everybody everywhere, holding even the possibility of destroying the species. Also crucial was the quality of IPPNW's leadership: Bernard Lown from Boston and Evgueni Chazov from Moscow worked together to provide direction and motivation

at a time when the temperature of the cold war was glacial. The organisation also benefited from being élitist, however uncomfortable it felt to many doctors at the beginning. Concentrating on doctors as members made it easier to cross boundaries: cardiologists from Venezuela can talk with cardiologists from Korea in a way that social workers or nurses cannot match. Doctors also carry more clout than most other groups in most societies.

The main challenge for IPPNW now is to redefine its mission, and the danger is that what emerges will be too woolly. As well as being clear and focused the mission should capitalise on the other strengths of IPPNW. Thus it should take on a huge and immediate threat to everybody everywhere to which doctors can make a special contribution.

Stockholm hummed with ideas. One proposal was to stick with something close to the original mission. The chance of the United States and the Soviet Union mutually destroying each other may be much reduced, but there are almost as many nuclear weapons in the world as ever. The chance of massive destruction is still present, not least because nuclear weapons are spreading to countries like Iraq. But people do

not feel as passionately about nuclear weapons as about nuclear war, and the energy and membership of IPPNW will surely dissipate with what is little more than a restatement of its original mission.

The next proposal was to extend the mission to cover conventional war. The horrors of this were brought back to everybody by the Gulf war, and the world has never had fewer than a dozen wars running concurrently since the second world war. Unfortunately, these wars do not galvanise doctors from Wichita, Rheims, or Doncaster in the way that the threat of nuclear war does. Furthermore, conventional war—unlike nuclear war—has winners and losers, and doctors may find themselves on different sides. An extension of the IPPNW mission to dealing with conventional war may thus not be enough to keep the organisation vibrant. An extension to chemical and biological weapons suffers from similar problems.

The other major proposal is to encompass the whole of “global security.” Andy Haines, professor of primary care in London, argues the case for this move in the impressive new journal *PSR [Physicians for Social Responsibility] Quarterly*.¹ The proposal is based on global security being seriously threatened not only by nuclear war but also by climatic change, the widening division between rich and poor, and profligate energy consumption by the richer countries. These threats are linked in myriad ways. For example, diversion of

resources to military arsenals perpetuates underdevelopment; a nuclear or chemical war may arise now not between east and west but between rich and poor; and military machines are prominent in energy consumption, which in its turn drives climatic change.

If IPPNW was to extend its mission from nuclear war to global security it would be tackling an issue that threatens everybody everywhere. It is also a mission to which doctors can legitimately contribute with their ancient duty to argue for the health of all people and their ability to cross national, racial, and religious boundaries. But can the mission be sufficiently focused and can divisions be avoided? Debates on overpopulation, for instance, may be seen as the rich trying to stop the poor breeding, and religious beliefs may make it difficult for all doctors to work together on such an issue.

The mission should be extended to global security, but it may prove impossibly difficult to define and focus the mission in a way that will inspire doctors everywhere. A mission that cannot be instantly grasped is useless. But IPPNW must survive. It is too special and creative an organisation to be allowed to wither.

RICHARD SMITH

Editor, BMJ

1 Haines A. Global security: a role for health professionals. *PSR Quarterly* 1991;1:89-95.

The practice manager

A rising star

In the 1950s the doctor's wife usually dealt with the limited administration required by her husband's practice.¹ Today most practitioners, including an increasing number of women, are working from purpose built premises, and their spouses are involved only in answering the telephone out of hours. Administration and managerial support have now been professionalised. This revolution began with the general practitioners' charter of 1965, which included “the ancillary staff scheme.” This reimbursed practices for 70% of the salaries of staff employed.² As the number of staff has steadily increased and group practices have proliferated senior receptionists began to be asked to carry out administrative duties.³

With time and fashion senior receptionists became known as “practice managers,” although they were really practice administrators. Only now as primary care becomes more complex is their management potential being appreciated and exploited.⁴ Practice managers may now be responsible for communication, coordination, staff, and information and planning.⁵⁻⁸ They may be invaluable in making administration more professional and helping practices to cope with change.⁹

In times of change management increases in importance. The new contract for general practice,^{10,11} the separation of purchasers and providers,¹² medical audit,¹³ indicative prescribing,¹⁴ and fundholding¹⁵ have all shaken the foundations of primary care recently. Medical audit affects all practices, and its demands on time and organisation may be daunting. A manager skilled in collecting, analysing, and presenting data can release doctors to concentrate on the issues raised by audit. With cash limits on staff, premises, and drugs practices must now compete for resources for development. Success will depend crucially on practices drawing up convincing and

realistic business plans, a process which skilled practice managers will take in their stride.

For fundholding practices financial skills will be particularly important. Shopping around to achieve the right mix of services at the best price will require detailed information on options. For example, a practice manager would not only identify the best hospital physiotherapy service within reach but also examine the cost implications of the practice employing a physiotherapist to deliver the same service “in house.”

Some general practitioners can and will want to fulfil this managerial role themselves, but most will not want their clinical interests to take second place to these skills (which will take time to acquire). Wise general practitioners will not abdicate these responsibilities but delegate them. Practice managers may well help to develop a broad strategy for the practice and will certainly be charged with its implementation. In this way general practitioners may retain control of their business without becoming bogged down in its day to day running.

It seems extraordinary that practice managers were officially excluded from the regulations for staff reimbursement until last year's new contract regularised reimbursement for them, but the 70% level may now be varied by individual family health services authorities.¹⁶ The substantial payments made to practice managers by fundholding practices acknowledge the managerial and financial skills that they require. Given their contribution to a practice's efficiency, managers may well expect their fixed salaries to be supplemented with performance or profit related pay.

Although courses exist to improve skills among current employees,^{8,17} practices will increasingly look outside for a practice manager. Realising that managerial skills are largely