cos e antihistamínicos carecem de bases fisiopatológicas justificativas, devendo ser abandonado. A vigilância das pneumopatias nas primeiras 24 a 48 horas de tratamento e após a conclusão do mesmo, deverá ser uma regra. Também nesta fase se justifica a adopção de critérios, de forma a seleccionar os doentes que realmente possam vir a beneficiar da realização do Rx de tórax de controle. Deverá ter-se sempre em conta que a resolução duma condensação pulmonar poderá demorar até 4 a 6 semanas, com as infecções virusais a serem as mais lentas nas recuperações radiográficas.

A **bronquiolite**, definida como "o primeiro episódio de tosse, pieira e hiperinsuflação em criança com menos de dois anos de idade", afecta pelo menos 10% das crianças no primeiro ano de vida, dos quais um quinto necessitará de vigilância ou internamento hospitalar.

O VSR é o principal agente etiológico, sendo responsável por cerca de 75% dos casos. A subjacente necrose do epitélio dos pequenos brônquios, associada à inflamação da mucosa e submucosa e à produção de vários mediadores químicos, todos contribuindo para a obstrução estrutural e funcional dos pequenos brônquios, com consequente obstrução parcial (insuflação) ou total (atelectasia) dos alvéolos a jusante, justifica a potencial gravidade clínica da bronquiolite.

Nos três primeiros dias de doença, a progressiva gravidade do quadro clínico, justifica uma vigilância apertada nos dois dias seguintes, se a criança foi observada nos dois primeiros dias de doença. Deverá igualmente ter-se sempre em conta os factores de gravidade – idade inferior a 3 meses, ex-prematuro (<34 semanas), ocorrência de apneias, cardiopatia congénita, displasia broncopulmonar, recusa alimentar, letargia, SDR progressivo com FR > 70 / min, Rx de tórax com atelectasias – justificando a referência hospitalar.

Quality Issues in Respiratory Medicine

WARREN H PERKS*

Throughout Europe there is a demand to put into place systems which will reassure the public about rnonitoring and maintaining standards by our profession. The process to ensure that standards are met is termed "clinical governance" (defined as the act af regulating proceedings clinically), which is undarpinned by lifelong learning (continual professional development – CPD) to provide doctors with the opportunities to update their skills and knowledge, as well as modernising and strengthening professional self-regulation.

CPD is the acquisition of new skills and knowledge, both of a specialist and non-specialist nature. There are many aspects to CPD. Evidence-based medicine is the process where clinical management of the patient is based on high levels of evidence obtained by quality clinical trials. It is also recognised that the simple act of talking and communication with colleagues is probably the most important way of gaining knowledge. The reading of journals, textbooks, following clinical guidelines, participating in grand-round, multidisciplinary meetings and teaching all contribute to the clinician's knowledge. Other learning resources include research, attendance at national scientific meetings, international meetings and sabbaticals. Finally, the pharmaceutical compani-

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es can provide up-to-date (albeit sometimes biased) information on drug treatments.

It is recognised that patient groups, insurance companies, medical managers and the Government, as purchasers of health care, wish for a high quality service. However, quality is difficult to define and assess. It is no longer acceptable for the profession to act without providing quality measurements, although at the moment it is recognised that these are not universally fair.

Currently the best methods of measuring quality is monitoring continuous professional development by CME points, monitoring performance by medical audit, monitoring departments by peer review and monitoring the whole process where possible by quality indicators and outcome measures. There are limitations to these crude tools. CME measures attendance at meetings and nothing more. Audit is time-consuming and often only measures easily measurable outcomes, it tends to be local and does not compare clinical activity from one hospital to another. The peer review system is very good for staffing, resources, education and networking, but has a tendency to be self-congratulatory. Quality indicators and outcome measures are currently at a rudimentary stage of development for medicine.

It is important that the medical profession ensures that it provides a quality and cost-effective service to its patients and society, before this role is undertaken by others (for example patient pressure groups, non-clinical managers and politicians). It is vital that adequate infrastructures are in place, eg staffing and funding. Nonetheless, the systems that are put into place should have the potential to detect team or individual problem areas at an early stage, to avoid sanctions or suspicions which undermine public confidence and threaten clinicians and their teams. Rectification of any problem rather than punishment should be the aim of clinical governance.

Training Issues for Pneumonologists in Europe

WARREN H PERKS*

The UEMS advises the European Commissioners via the permanent committee of EU Doctors on training aspects within Europe. The rnission statement of the UEMS 1994 is that the doctors in training should, at the end of his/her training, have gained broad theoretical and scientific knowledge of respiratory diseese and all conditions affecting the lung, as well as having wider clinical experience. After training the doctor should be able to make independent decisions within all areas concerning respiratory disease and take care of both acute and non-acute patients. At the end of training the doctor should be able to audit and advise upon research projects relative to the speciality and to participate as a tutor and teacher in the field.

The UEMS advocate harmonistation of training within the EU. Firstly, by virtue of European law, secondly because of the free movement of both patients and doctors within the EU, thirdly to promote shorter training, and finally to ensure quality training throughout Europe.

The mean length of training within Europe is 12.6

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