commentator stated that not even necropsy could ever prove the brain had been dead in these circumstances. Perhaps the forensic pathologist, who is admittedly concerned mainly with cases arising from severe head injury, gets a distorted view. Nevertheless, it has always seemed to me that the concept of brain death allows physicians and surgeons actually to slow the tempo. Its primary function is to allow physicians to remove from artificial support a patient who is very clearly dead. The advised tests are, in effect, confirmatory of a condition which has been able to develop with time so as to be obvious. Despite the categorical statement made in the programme, I personally have no difficulty in concluding that a liquefying brain is dead.

There were also certain individual items which I found unreasonably biased, not least the lady who heard a policeman say something to the effect that "this one's a gonner." Since no doctor appeared to have agreed with this it seemed hard on them to introduce her as one narrowly rescued from living organ donation.

Following the *Panorama* programme, I switched to an admittedly fictional representation of an American special hospital and could not help wondering if the BBC would regard this as indicative of conditions at Carstairs. Mercifully, visitors arrived during the intermission for the news, so I was unable to follow it to its conclusion.

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SIR,—Printing deadlines and the need for instant copy following last week's *Panorama* programme led, I am afraid, to certain omissions from my review (18 October, p 1064).

The American collaborative study¹⁻³ (to which the programme referred) collected useful data concerning brain death. It cannot unfortunately be considered definitive, as Mr Richard Lindley seemed to imply in presenting the programme. "Although the protocol required that blood be drawn in every case half of the patients admitted to the study never had blood analysed for intoxicants." Concerning hypothermia, the summary further admits that "the possibility of error existed in seven patients in which the temperature was not taken." Concerning isoelectric electroencephalograms (EEGs) it is pointed out that "there was only [sic] a 3% disagreement between the review panel and the original reader"—a difference deemed "inevitable in the present state of the art of electroencephalography." In this context it is difficult immediately to identify the two critical cases to which Korein referred in the programme.

A major shortcoming of the collaborative investigation, is that its widely publicised summary³ does not stress—as the British code of practice does—that a positive diagnosis of the cause of the patient's apnoeic coma must *always* be established *before* a diagnosis of irreversible brain death is even envisaged. The recording of an isoelectric EEG may actually obstruct such an endeavour. It may even be positively misleading: reversible isoelectric EEGs have been reported following the massive ingestion of barbiturates, methaqualone, diazepam, mecloqualone, meprobamate, and trichloroethylene.⁴

By far the most telling criticism of the American collaborative study centres, however,

on its concept of apnoea. Five hundred and three "comatose and apnoeic" patients were admitted to the study; but, as Black⁴ points out, the concept of apnoea was different from that used in any other study of the subject. The two main reports of the study^{2,3} do not mention disconnection from the respirator (to assess respiratory effort) as being required. The yardstick for "the absence of spontaneous respiration" was that for a period of 15 minutes "the patient made no effort to override the respirator." A few lines in the appendix to an atlas of electroencephalography⁵ do mention disconnection but leave its duration "to the judgment of the attending physician." It is obvious that the prognostic inferences to be drawn from one level of "apnoea" (not "tripping" the respirator) might differ widely from those to be drawn by a stricter clinical criterion—namely, no inspiratory effort after 10 minutes of disconnection. This is done, in the UK, for a specified period of 10 minutes following preoxygenation with 100% oxygen for a similar period and the administration of 5% carbon dioxide in oxygen to ensure that the arterial carbon dioxide pressure at the moment of disconnection exceeds the threshold for respiratory stimulation—namely, 6.65 kPa (50 mm Hg).

Concerning the case of Dave Churchill, my review should have read: "Proper clinical testing would have revealed the true state of affairs. Except in patients with certain (pseudocholinesterase) enzyme deficiencies the pupils would still have reacted to light, and the use of a nerve stimulator would have shown the block in neuromuscular transmission."

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¹ Korein J, ed. *Ann NY Acad Sci* 1978;315:1-454.

² Walker EA, Diamond EA, Moseley J. *J Neuropath Exp Neurol* 1975;34:295-323.

³ Collaborative Study. *JAMA* 1977;237:882-6.

⁴ Black PM. *N Engl J Med* 1978;299:338-44.

⁵ Bennett DR, Hughes JR, Korein J, et al. *Atlas of electroencephalography in coma and cerebral death*. New York: Raven Press, 1976.

⁶ Powner DJ. *JAMA* 1976;236:1123.

Management of patients after self-poisoning

SIR,—In discussions between our two colleges it has become apparent that there have been a number of changes in the management of persons admitted to hospital with self-poisoning. The previous recommendation of Sir Denis Hill's committee some years ago was that all such patients should see a psychiatrist before discharge. In many parts of this country this has been more honoured in the breach than the observance, sometimes because some patients discharge themselves, refusing to see a psychiatrist, sometimes because the psychiatrists themselves are not available at short notice—and, finally, because medical and nursing staff may feel that they themselves can carry out an adequate evaluation.

This last consideration has been the subject of some research in recent years. Good evidence has now been obtained that in certain circumstances an adequate assessment can be carried out by non-psychiatrists. We would stress that every patient admitted with self-poisoning, however trivial, must have an adequate evaluation of the situation which led

up to the overdosage and of his or her mental state. Current stresses are often of such a kind that with relatively little help from suitably trained staff a generally better psychosocial adjustment can be obtained and further suicidal tendencies reduced. This is important, since numerous studies have shown that there is a greatly increased chance of subsequent suicide after any overdose. Comparatively simple questions that should be asked by every admitting medical officer, however junior and overworked, will divide persons into those of high and low risk. Most of the routine psychological data required to decide what further action is needed can be obtained by a person who has been properly trained for this and the most appropriate medical decision can then be taken.

All this, however, is of value only if, in addition, there is the back-up of a full and easily available psychiatric service for immediate consultation (by telephone, if necessary) and for more intensive psychiatric treatment, if required, as an inpatient. The psychiatrist should be responsible for the quality of the training of the medical and non-medical personnel and be available regularly for supervision and staff support. We think it is important that every hospital admitting more than the occasional patient with overdosage (and there can be few that do not admit any such patients) has a clearly laid down policy agreed by physicians, psychiatrists, and all other staff with regard to the management of self-poisoning persons. There must be the will to see that this policy is understood and implemented by new house officers and junior ward staff after appropriate training.

Finally, for those wanting more background information, we would draw attention to the recently published symposium *The Suicide Syndrome*.¹

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¹ Farmer R, Hirsch S, eds. *The suicide syndrome*. London: Croom Helm, 1980.

Vaccination against smallpox

SIR,—I should like to comment on the letter by Dr Dilwyn T Jones (11 October, p 1004) in my capacity as secretary of the joint co-ordinating committee of the three defence societies.

In the first place, I cannot agree with Dr Jones's interpretation of the Chief Medical Officer's view. I would suggest that the CMO is not saying that vaccination against smallpox is a matter for the personal opinion of the doctor. What he is saying is that apart from a very small category there is no medical indication for the procedure, and that patients should be told just this.

I must disagree again with Dr Jones when he says that the medical defence societies say that doctors should refuse to vaccinate anyone. What the societies have said, as Dr Jones reports quite accurately, is that the defence of a medically contraindicated procedure which results in harm is difficult. In the light of this difficulty, the societies have proposed an alternative which will both protect the patient from the clinical hazard and the doctor from the medicolegal one. Far from there being two different recommendations, I would suggest