of couple therapy, whether analytically or behaviourally based, focused on the couple's interaction and mutual projections are totally different from the psychodynamics of one to one examination of an individual's personal anxieties.

Nigel Mather and colleagues' paper attempted only to assess how far achievement of this brief technique is possible by seminar training with leaders who are not psychoanalysts.³ It is good to know that the multidisciplinary British Association of Sexual and Marital Therapists has now begun to offer training and is using the seminar method. I look forward to its assessment of results.

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Should relatives watch resuscitation?

A haunting experience in Nepal

EDITOR,—I wish to contribute my experience to the debate concerning whether relatives should be allowed to witness resuscitation.^{1,2} While I was a medical student doing my elective in Nepal a large earthquake occurred there. In the first 24 hours afterwards the hospital, staffed by three doctors and three medical students, was overwhelmed by 500 casualties. On the same day a 35 year old woman attempted suicide by ingesting organophosphorus weedkiller. Her husband had left her for her younger sister, and she was thus homeless with four children. Debate ensued: in view of the hospital being overrun by earthquake victims should she be treated? The potential consequences of her death to her children, however, led to her being admitted to a makeshift intensive care unit. Her children slept on a bench on the veranda outside.

In the absence of a bleep system a cardiac arrest occurring in the unit was signalled by the wail of an old air raid siren. The women arrested and was resuscitated several times before dying. Unfortunately, the siren also acted as a signal to the children. Each time we performed cardiac massage and defibrillation on the woman we were aware of four forlorn faces pressed up against the window. What did they think we were doing to their mother? How could we stop attempts at resuscitation when to admit defeat would bring such miserable consequences to our audience? I am still haunted by the experience. I suspect the children are too.

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- 1 Adams S, Whitlock M, Higgs R, Bloomfield P, Baskett PJF. Should relatives be allowed to watch resuscitation? *BMJ* 1994;308:1687-9. (25 June.)
- 2 Correspondence. Should relatives watch resuscitation? *BMJ* 1994;309:406-7. (6 August.)

Opportunity is appreciated

EDITOR,—I am surprised that the article and subsequent correspondence discussing whether relatives should watch resuscitation have paid such little attention to the feelings of the resuscitation team.^{1,2} Most doctors would admit that resuscitation is stressful. People cope with anxiety in several ways, but most medical staff seem to try to

do this by using a mixture of humour and detachment from the patient. Both of these are difficult to use in the presence of a relative. Doctors and nurses often feel less confident, guilty, and sad after a failed attempt at resuscitation. The presence of a relative, who is usually emotionally distraught, puts the patient into context as someone's father, husband, or child and negates this coping strategy.

I have worked in an accident and emergency department where relatives were invited to watch resuscitation while accompanied by a senior member of the nursing staff. I and other team members found it harder to cope when relatives were present at resuscitations. This was recognised in the department, and measures were taken for staff to recharge their emotional batteries and have time to offer support to each other. Relatives often expressed how much they had appreciated the opportunity to witness the resuscitation. I believe that allowing relatives to witness resuscitation is beneficial and should become more widespread, as should recognition of the staff's need for coping strategies in this stressful situation.

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- 1 Adams S, Whitlock M, Baskett PJF, Bloomfield P, Higgs R. Should relatives be allowed to watch resuscitation? *BMJ* 1994;308:1687-9. (25 June.)
- 2 Should relatives watch resuscitation? [Letters.] *BMJ* 1994;309:406-7. (6 August.)

We have no regrets

EDITOR,—R J Schilling's letter suggesting that relatives should be prevented from watching resuscitations seems to us to represent two of the worst foundations for medical practice: arrogance and anecdote.¹ Beliefs that patients and relatives should be present only at the convenience of the doctors and that the doctor knows best are sadly outdated. The use of one anecdotal experience to guide clinical practice is also unacceptable.

We were both present at the unsuccessful resuscitation of our 7 month old son last year. It was a traumatic experience that will haunt our memories for a long time, but we have no regrets about having been there. Attempts to usher us away while our child was dying seem incomprehensible, and we can understand the favourable response of parents and relatives allowed to watch resuscitations. We could not have surrendered or abandoned our child at such a critical time to a group of anonymous doctors. We believe that few parents would want, or should be forced, to do so.

New ideas will always take some adjusting to, but there is little excuse for denying relatives the choice of being present at resuscitations. Doctors may have to control their attempts at black humour, but our own professional experiences during resuscitations suggest that this would be no bad thing.

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- 1 Schilling RJ. Should relatives watch resuscitation? *BMJ* 1994;309:406. (6 August.)

Hearing voices

EDITOR,—As the editors of *Accepting Voices*, the book reviewed by Raymond Cochrane,¹ we believe that the sentences that he quotes are so taken out of context as to be misleading. For example, he quotes, "It is unfortunate that hearing voices is

designated as auditory hallucinations because that presumes the existence of pathology." This might sound strange, since half of the patients diagnosed as having schizophrenia suffer from auditory hallucinations, until one realises that only a third of people who hear voices have a mental illness. Tien and Eaton *et al* have shown that 2% to 4% of the population have these experiences.^{2,3} In separate epidemiological studies they have shown that the phenomenon is related to a psychiatric illness in only one third of people who experience it. Hearing voices is too often taken to indicate schizophrenia.⁴

Cochrane quotes another sentence out of context: "[Romme] advises voice hearers to cope with their voices by accepting 'the presence of an influence lying outside [themselves], but grasp fully that it is not more powerful than [themselves]'. " This also sounds strange in isolation. Cochrane himself refers to the fact that "the most widely used method is to treat the patient with neuroleptics, but some patients have drug resistant hallucinations which require other treatments." It is in patients requiring alternative treatment that we have explored the efficacy of other methods. We have found that advising some of these people that the voice is outside themselves is helpful. Many people tend to believe that what the voices say is the truth, but they can be helped to have a dialogue in which that is not thought to be so. This often reduces anxiety, allows them to realise that the content may be nonsense, and helps them to gain control.

When a medical approach fails, as it does in 60% of cases of auditory hallucinations, ways of learning to cope with the hallucinations remain, and these are central to the ideas we were presenting. English academic research workers—for example, Bentall *et al*⁵—are also exploring alternative treatments.

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- 1 Cochrane R. Hearing voices [book review]. *BMJ* 1994;308:1649. (18 June.)
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Child resistant containers

EDITOR,—In her letter about accidental ingestion of methadone by children Michelle Jacobs raised the question of the use of child resistant containers for liquid medicines.¹ Child resistant containers have been used for solid dose medicines for several years, and the Royal Pharmaceutical Society of Great Britain has been trying for some time to extend the use of such containers to liquid medicines.²

There has been considerable difficulty in producing a child resistant container—that is, bottle and cap—that can be used for liquid medicines without the cap sticking as a result of the sugar in many of the medicines. Despite the potential difficulties, in 1991 the society advised its members to dispense methadone, as a special case, in child resistant containers.

A new shape for the neck of standard medicine bottles has now been approved by the British Standards Institution, and bottles and caps are being produced to meet these new requirements.

As a result the Royal Pharmaceutical Society of Great Britain issued a statement to pharmacists last April, saying that all dispensed oral liquid medicines should be supplied in a child resistant container from 1 January next year. As supplies of these bottles and caps become available during this year they will begin to be used by pharmacists.

Discussions are currently taking place between the society and the pharmaceutical industry about the use of child resistant containers for original pack oral liquid medicines; it is hoped that the containers will be used for these by 1 January 1996.

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1 Jacobs M. Accidental ingestion of methadone. *BMJ* 1994;309:53. (2 July.)

2 Odd RW. Child resistant containers for liquid medication. *BMJ* 1993;306:460.

Melanoma in Britain and British Columbia

EDITOR,—Joan Austoker's review of malignant melanoma omits to compare the incidence of the disease, and survival from it, in Britain with that in the rest of the world.¹ The table compares the British figures quoted with those from British Columbia, Canada, over a similar period.² Such differences in incidence and survival should be a cause for concern in Britain.

Depth of primary tumour, five year survival, and proportion of primary tumours on extremities in patients with melanoma in Britain and British Columbia. Values are percentages

	Primary tumours with depth <1.5 mm	Survival at 5 years		Primary on extremity	
		Men	Women	Men	Women
Britain	39	52	75	42	73
British Columbia	60	70	83	28	62

Better prognosis for women compared with men in British Columbia was related to thinner primary tumours (median depth 1.1 mm in women and 1.45 mm in men).² The duration of symptoms in men and women was 5.6 and 6.2 months respectively, suggesting that differences in survival between the sexes are not related to earlier recognition of melanoma. The difference in survival between the sexes is attributable to longer intervals to recurrence, while survival after recurrence is equivalent.²

Ethnic differences are unlikely to contribute to the differences in the incidence of melanoma and survival between British Columbia and Britain since the population of British Columbia is mostly of Scottish origin. The distribution of the primary site favours British patients (more melanomas on the extremities), yet survival favours patients in British Columbia.

Differences in education and medical practice have to be considered as potential reasons for the observed differences in the depth of melanoma and survival between British Columbia and Britain.

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Bone marrow transplants from peripheral blood

EDITOR,—Reinfusion of peripheral blood stem cells to repopulate the bone marrow after myeloablative chemotherapy is being increasingly used to intensify treatment for haematological and other malignancies.¹ We could find no published data on the practicalities of returning the cells to the patient through a central venous line. One method is to inject the stem cell suspension with a syringe, but problems may occur in maintaining sterility; in addition, too rapid injection may result in an adverse reaction to the cryopreservative (dimethyl sulphoxide) in which the cells are suspended.

An alternative method is reinfusion with a standard blood giving set, but, using this technique, we have observed accumulation of cellular sediment within and around the 170 µm filters of such sets. Since the cell suspension harvested with a Haemonetics V50 cell separator contains platelets of the order of 10¹²/l these were probably contributing to the cellular sediment in the filter bulb, but we were concerned that stem cells might also be trapped and wasted in the sediment. Three patients who had received myeloablative treatment for high grade lymphoma each received reinfusions of two bags of stem cells. The concentration of CD34 positive cells (putative stem cells) in individual bags of harvested cells was measured before and after the cells' passage through blood giving sets. There was no significant change in concentration of these cells ($P > 0.05$, paired t test), and the procedure was successful in all three patients.

It is reassuring that peripheral blood stem cells can be returned to a patient in a sterile and easily controlled way with a standard blood giving set without appreciable loss of cells.

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1 Holyoake TL, Franklin IM. Bone marrow transplants from peripheral blood. *BMJ* 1994;309:4-5. (2 July.)

Assessing change through audit

EDITOR,—In his commentary¹ on the multicentre criterion based audit of the management of induced abortion in Scotland² Ken MacRae makes a telling point about the risk of double standards in the assessment of audit rather than research papers. He is right to challenge the view expressed in "Editor's choice" that without such double standards "the *BMJ* would rarely have published any papers on audit." The methodology of research needs to fit its purpose, and the current accepted gold standard of the randomised controlled trial is appropriate when research compares different interventions. It would be unhelpful to suggest that a lower standard is acceptable merely because a study is called an audit.

There is potential confusion, however, about the nature of the intervention being studied here. The intervention being tested is not priming with mifepristone but the effectiveness of the audit process in generating changes in service derived from expert review. MacRae's points about the robustness of the conclusions to be drawn from the study still hold, but the consequences of publishing an erroneous finding are much less. At

worst, other groups will misguidedly use the authors' methods for disseminating information on good practice when in fact the improvements were due to confounding effects, such as parallel publication. If, however, the authors had claimed from the results of such a study that morbidity had changed as a result of increased use of mifepristone then MacRae's strictures would have been crucially important.

The debate about appropriate methodology for audit is complex, but two further points are relevant. Firstly, the audit process often challenges received wisdom in medicine, which itself may never have been subject to randomised controlled trials. In this situation it is helpful to publish provisional findings, which can then be scrutinised more exactly. Secondly, there is an assumption that the best methodology is always a randomised controlled trial. Audit requires a diversity of methods that are optimal for different questions. Measurement of "clinically significant change" might be a useful technique for locating individual patients in an audit within a framework delineated by reliable measures of change derived from larger samples. Howard *et al* suggest that the limits of randomised controlled trials need to be considered when appropriate audit methods are chosen: the difficulties of attrition, generalisability, the need for unambiguous main effects.⁴ All of these are challenges to the utility of the randomised controlled trial as the best available methodology in systematic audit.

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2 Penney GC, Glasier A, Templeton A. Multicentre criterion based audit of the management of induced abortion in Scotland. *BMJ* 1994;309:15-8. (2 July.)

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Complementary therapies used by patients with cancer

EDITOR,—S M Downer and colleagues found that 16% of patients with cancer had used complementary therapies.¹ We wish to report a study that we are carrying out.

Between September and 31 October 1993, 327 consecutive unselected patients starting treatment with radiotherapy at Mount Vernon Centre for Cancer Treatment were asked to complete detailed questionnaires about their treatment and psychosocial support. These included a hospital anxiety and depression scale, a cancer locus of control, and the European Organisation for Research and Treatment of Cancer's quality of life questionnaire C30 (a general quality of life questionnaire). We also collected detailed clinical, social, and demographic data. Of the 268 patients who consented, 174 were receiving radical radiotherapy as opposed to palliative radiotherapy. One hundred and fifty eight patients were women, and the age range was 22-88 (mean 62.8) years.

Results from a questionnaire listing 40 complementary therapies show that 86 patients had used such treatment. While 22 patients had used only one treatment, 15 had used eight or more. Unlike Downer and colleagues, we regarded counselling, telephone helplines, and support groups as complementary therapies (table). While many patients availed themselves of these three services, this cannot account for the overall higher uptake in our study compared with Downer and colleagues.