intake of hindmilk and hence of vitamin K.⁴ If the baby needs extra vitamin K it can be given as a separate supplement.

Slattery makes some cogent points about the ethics of routine treatment of babies with vitamin K in the absence of controlled trials looking at possible side effects.^{1,5} Interpreting statistics on haemorrhagic disease of the newborn in relation to feeding and prophylactic treatment is extremely difficult. In the leaflets we have collected the incidence of haemorrhagic disease quoted to parents varies from 1 in 50 to 10 in 1.7 million babies. We welcome the developing debate on the size of the problem and the benefits and risks of the alternative preventive strategies. In particular, we value discussion about the appropriateness of a randomised controlled trial.

Despite the practical difficulties and the long wait for results² we believe that a trial is appropriate, given that the whole population of newborn babies is currently targeted. Careful attention should be paid to producing clear information based on research for all parents considering treatment for their child.

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Treating hypertension after stroke

EDITOR,—Janice E O'Connell and Christopher S Gray's editorial highlights the uncertainty concerning the optimal management of hypertension in acute stroke.¹ I disagree with the authors over the treatment of hypertension after intracerebral haemorrhage. They advocate treating high systemic pressures (systolic >200 mm Hg; diastolic >120 mm Hg) and quote a paper by Lavin in support of this.² Lavin in fact suggested that intracranial pressure, rather than systemic blood pressure, should be reduced. Although he added that treatment of systemic hypertension may reduce cerebral oedema, he qualified this by suggesting that systemic hypertension should be reduced by no more than 20% and that ischaemia of the border zone may result. In response to a subsequent letter Lavin clarified that his personal bias was to lower intracranial pressure and not systemic blood pressure.³

A recent review of decisions on treatment in acute hypertension after stroke concluded that the role of hypotensive therapy in intracerebral haemorrhage remains unresolved and that, as with cerebral infarction, there are cogent reasons for believing that reduced systemic blood pressure may worsen cerebral blood flow, with resultant ischaemic damage.⁴

Although O'Connell and Gray state that no randomised trials looking specifically at antihypertensive treatment in acute stroke have been published, such a study has been carried out in ischaemic stroke.⁵ Although the study was small, no clinical benefit was observed, but it was suggested that nicardipine and possibly other calcium channel antagonists may impair cerebral blood flow.

I believe that, until robust evidence exists to support the use of antihypertensive drugs in acute stroke (either ischaemic or haemorrhagic) in adults, these drugs should be withheld initially unless hypertensive encephalopathy or aortic dissection is present.

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- 1 O'Connell JE, Gray CS. Treating hypertension after stroke. *BMJ* 1994;308:1523-24. (11 June.)
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Running an emergency helpline

The media may exploit doctors

EDITOR,—In their article on how to run an emergency helpline Cameron Stark and colleagues state, "If information can be adequately transmitted by the media a helpline should not be needed."¹ Our experience is that dealing with the media is not that simple.

We recently conducted a look back exercise after learning that a health care worker at a local hospital was positive for HIV. We had wanted to avoid unhelpful and prejudicial publicity caused by insensitive handling of the subject by the media, and so we avoided contact with the press for as long as possible. Patients who needed to be traced were approached personally through their general practitioners, and the tracing exercise was completed without press coverage.

The media inevitably heard of the incident. Unnecessary anxiety was generated among the general public, and a helpline was set up to answer concerns that the media raised. Over 2000 calls were received in the first 48 hours, and peaks of calls coincided with the broadcasting of news bulletins. The helpline proved a useful way of conveying information but was costly in terms of time and staff. There were also obvious conflicts of interest between us and the news hungry press, not the least of which concerned the confidentiality of the health care worker. Fortunately, we were able to maintain this.

The relationship between the health service and the press can be a valuable one, but once the media get hold of what they perceive to be a newsworthy health issue doctors need to make sure that they use the media to their advantage and are not exploited.

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- 1 Stark C, Christie P, Marr AC. How to run an emergency helpline. *BMJ* 1994;309:44-6. (2 July.)

Guidance from NHS is required

EDITOR,—Cameron Stark and colleagues' article on how to run an emergency helpline described the actions necessary once the decision has been taken to establish such a helpline.¹ More pressing issues, however, are under what circumstances such

helplines are warranted and what constitutes such a serious risk to the patient that a "look back" exercise is needed. Over the past year such exercises have taken place in relation to helplines set up to provide advice on HIV and hepatitis B virus infection and unreliable results of cervical smear tests. In many cases the risk to patients may be remote, and the risk should be considered against the cost of such exercises and their tendency to provoke media alarm and public confusion.

The NHS Executive has no coherent overall view on look back exercises and no guidance for health authorities and trusts on the criteria for undertaking such initiatives and setting up helplines. Such guidance is needed to prevent unnecessary alarm among patients and to ensure that resources are directed towards such exercises only when there is clear risk to a large population of patients.

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- 1 Stark C, Christie P, Marr AC. How to run an emergency helpline. *BMJ* 1994;309:44-5. (2 July.)

Training in psychosexual medicine

EDITOR,—May Duddle's criticism of the Institute of Psychosexual Medicine's training is ill informed¹ as she has taken no part in the institute's training, research, and development, which have been carried out nationwide for 30 years. I wish to set the record straight.

Doctors accepted for basic training must expect to meet patients who expect examination of their sexual organs as well as emotional understanding; in general practice, patients come for family planning, genitourinary medicine, gynaecology, and andrology. Certain nurses, midwives, and obstetric physiotherapists also have to use intimate therapeutic techniques, and some join seminars with our accredited leaders. The clinical problems studied are thus wider than, though include, dysfunction in sexual performance. We expect our trainees to learn other techniques elsewhere: you would not expect to learn ear, nose, and throat surgery on an obstetric firm.

Training in seminars aims to convey a precise, extra psychosomatic skill (distinct from other non-directive verbal counselling and psychotherapy) to everyday consultations, whether they are for the overt presentation of sexual difficulty or marital discord; the fitting of a contraceptive or an intra-cavernosal injection; postmenopausal atrophy or a widower's impotence. In each case we examine less conscious aspects of the immediate doctor-patient interaction, considering what light they throw on other relationships. Secondly, we learn from the patients' reaction to, or anticipation of, genital examination something of their vision of their personal sexuality.

Duddle comments that we do not encourage partners to attend. Many young men with premature ejaculation or women with vaginismus are too anxious to be able to expose themselves to a partner, let alone to propose joining him or her in behaviour therapy. Furthermore, primary care doctors, unlike psychiatrists accepting referrals, must regard "the patient" as being whoever consults them. Much time in training concerns why doctors find themselves wishing to split up a couple who have elected to present together and, conversely, why in some cases doctors send for a partner they have never met, rather than noticing that they have a complaining or blaming patient before them.²

Finally, as an experienced psychotherapist Duddle will surely agree that the psychodynamics

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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- 2 Skrine RL, ed. Psychosexual training and the doctor-patient relationship. Carlisle: Montana Press, 1987.
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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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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.