Reference

DAVID, J. & PRIOR-WILLEARD, P. F. S. (1993) Resuscitation skills of MRCP candidates. *British Medical Journal*, **306**, 1578–1579.

DEAR SIRS

I was interested to read the article concerning resuscitation skills of psychiatric trainees by Kosky and Spearpoint (*Psychiatric Bulletin*, August 1993, **17**, 489–491) and endorse their recommendation that all doctors should have refresher courses on cardiopulmonary resuscitation.

It would seem that psychiatric hospitals are running tremendous risks in the way they are equipped to deal with medical emergencies and are fortunate that this is not exposed in the mass media. The risks are not purely because of poorly trained doctors in the skills of resuscitation, but in the rapidly decreasing time psychiatric nurses spend on general hospital placements in their training, in the poverty of equipment required in a medical emergency and in the level of complacency surrounding the notion that psychiatric patients are medically fit and healthy.

I felt that the authors had set their sights far too high; certainly if I was at the scene of a cardiac arrest in a psychiatric hospital and was presented with a defibrillator and an array of anti-arrhythmic drugs I would require as much resuscitation as the patient.

As a registrar in general psychiatry I was involved in two nightmares. The first required the rapid administration of intravenous fluid; a venflon was finally located on the patient's ward, a giving set on another ward, an out-of-date bag of saline in the extra care area at the other end of the hospital and no drip stand to be found. On another occasion a patient arrested following an overdose; she was maintained with cardiopulmonary resuscitation until an ambulance arrived. However, the ambulancemen somehow assumed that the patient could be transported down a large flight of stairs, through a long corridor and down another flight of stairs in a wheelchair, when she had no cardiac output. When they returned with an appropriate stretcher one of the ambulancemen himself was suffering from a severe asthmatic attack.

Following these traumatic experiences I have learnt the cardinal rules concerning medical emergencies in psychiatric hospitals.

(a) The patient needs to be removed from a psychiatric hospital as rapidly as possible. The first thing to do before initiating any procedures is to ensure that an ambulance is on the way and is aware that it is not a call to transfer routinely a patient from one hospital to another but that there is a real emergency.

(b) Anything other than first aid is unrealistic and dangerous. For example, to give drugs during an arrest assumes that there will be a competent nurse present to continue the cardiopulmonary resuscitation.

(c) Put in writing to the management your unease about the risks being taken.

(d) Hope that it is your colleagues who are on call when the next disaster occurs.

ALASTAIR NEALE

Young People's Centre
Mount Gould Hospital
Plymouth PL4 7QD

Thyroid microsomal antibody

DEAR SIRS

The paper by Suresh & Robertson (*Psychiatric Bulletin*, August 1993, **17**, 477–478) prompts me to direct attention to thyroid microsomal antibody (TMA) concentrations, an additional component of thyroid dysfunction in the population with Down's syndrome (Kohen & Wise, 1992).

In this study of 30 randomly selected clinically euthyroid Down's syndrome subjects, TMA concentration results showed that 40% (n = 12) had positive TMA (titre > 40), of whom nine were aged under 50 and three over. Of the individuals negative for TMA, five were under 50 and 13 over ($P = 0.03$). The study concluded that this different of circulating TMA in subjects with Down's syndrome over 50 years of age could be the result of selective mortality of the younger group with positive TMA results.

Investigations of the high prevalence of thyroid dysfunction in Down's syndrome has brought great improvement to their wellbeing. The study of TMA concentration results may also bring new insight into the high rates of coronary heart disease, vascular and immunological disorders and Alzheimer's disease in this population. I believe that regular screening for thyroid dysfunction should be supplemented by TMA results to clarify this possible interaction between thyroid, immunology and pathology in the other systems of the Down's syndrome population.

DORA KOHEN

Charing Cross Hospital
London W6 8RF

Reference

KOHEN, D. & WISE, P. (1992) Autoantibodies in Down's syndrome. *Lancet*, **340**, 430.

Second medical recommendations

DEAR SIRS

I was interested to read the article on second medical recommendations for the Mental Health Act (Ung, *Psychiatric Bulletin*, August 1993, **17**, 466–468). This highlighted, particularly in the case of general practitioners, the lack of independence in these assessments.

This put me in mind of a long serving medical records officer who commented on the clinical descriptions accompanying medical recommendations. His years of experience had led him to observe that for many general practitioners the accompanying description bore a remarkable similarity to that of the psychiatrist and, in fact, was often of the same wording. It is clear that many GP's do not feel sufficiently confident to form an independent assessment, nor to challenge the opinion arrived at. This is contrary to the spirit of the mental health legislation and deprives the patient of an autonomous assessment by a second doctor.

This situation is unlikely to be rectified unless the GPs providing theses assessments have obtained sufficient training and experience, so enabling them to fulfil the role envisaged by the legislation. The average GP is involved very infrequently and perhaps it would be more appropriate to have a panel of suitably, qualified GPs for this purpose. Where the individual patient's GP is not on this panel then an approved doctor could provide the recommendation.

HARRY DOYLE

Guy's Hospital
London SE1 9RT

Recruitment of patients with panic disorder

DEAR SIRS

We read with interest Dr Dratcu's article on the recruitment of patients with panic disorder through a magazine article on the subject (*Psychiatric Bulletin*, July 1993, **17**, 416–417). This is similar to our experience at the Royal London Hospital in recruiting subjects with panic disorder.

Initially requests were made for patients with panic disorder to psychiatric colleagues, CPNs and local GPs. The response was poor with just three patients referred, not all of whom were suitable. This led us to place a small 10 × 7 cm notice of our interest in subjects with panic disorder in a local paper. Over 60 telephone enquiries were received and a detailed questionnaire sent to respondents. Thirty-eight returned the questionnaire (11 male and 27 female), the majority of whom described clear panic attacks. Only 11 patients reported current contact with their GP (and as such available to be referred from this source). Fourteen patients reported no contact at all with their GP or hospital for panic disorder although most met the trial criteria.

We were concerned we might recruit subjects (with generalised anxiety disorder) addicted to benzodiazepines. Surprisingly this was not the case, with only eight reporting current benzodiazepine use. A further ten were receiving antidepressants, beta blockers or neuroleptics (3) and 18 were receiving no medication.

A notice of interest in panic disorder placed in a local paper therefore results in a good response with many cases being recruited who have not previously presented to medical services.

RICHARD DUFFETT
J. COOKSON

Royal London Hospital Trust Department of Human Psychopharmacology
London E3 4LL

Psychiatry and the media

DEAR SIRS

I am writing to reiterate the concern of many psychiatrists (including that of Clark, *Psychiatric Bulletin*, July 1993, **17**, 440) who are appalled by misinformation being conveyed by the media to unsuspecting laymen about psychiatric ailments and their treatment.

On 5 May 1993 BBC ('The Family Game', QED) introduced a child as a 'problem child' on the national network. It is of great concern to those who respect the individuality and confidentiality of children in these matters that such a presentation should be made. It is difficult to comprehend the ethics of presenting an innocent child who surely did not understand the nature and purpose of this recording, nor had the ability to give consent. A few generations of psychiatrists have expressed concern about the stigma and labelling that psychiatric ailments attract. I dread the day when the child presented on the national TV network grows up and asks "why did you do this to me . . .?"

My concern increased by the time the programme concluded as there was no evidence in the presentation, historical or from the programme, that the treatment proposed was effective. The actual game seemed to be the interviewers filling in forms, drawing conclusions, making assumptions about things said and unsaid and keeping pressure on their clients until the final aim was achieved; this seemed to be the self-gratification of the therapists when mother entered the game, yielded to all pressures and declared how good they were and how ignorant she was.

There may have been a satisfactory change in the child with therapy. Only the clinician treating the child will know for sure. However, whether it was brought out in the presentation or whether consideration was given to the implications it will have on the future wellbeing of this child, are questions which need to be asked. Our College must contribute to programmes on psychiatric issues to ensure that the programmes imply consensus professional opinion.

DINESH K. ARYA

University Hospital
Queen's Medical Centre
Nottingham NG7 2UH