LETTERS TO THE EDITOR

Should relatives be allowed in the resuscitation room?

ERROR—I welcome the paper by Mitchell and Lynch. Did the sentiments behind it but as a specialist in the psychology of trauma I feel compelled to comment upon it. The only way of preventing post-traumatic stress reactions or mental illness is by not exposing individuals to traumatic events. Once exposed there is little evidence that it is possible to prevent them as their genesis is complex. Society today does indeed have a view about what we get up to, which is informed by such excellent TV "dramination" such as Casualty or ER. We must however recognise that relatives will not see resuscitation as we do. They have no training and will be highly emotionally charged or even "dissociated". We must be aware that individual's reactions to trauma are very different, many may cope well, but others will decompensate, but all are affected to a greater or lesser degree. Every relative deserves and has a right to access to compassionate holding and caring, but care must be taken not to brutalise them at a time of intense vulnerability.

I broadly welcome this initiative but question our responsibility to potentially bereaved individuals. As the only certainly in life is death and grief and bereavement are painful, we must be careful in assuming that watching resuscitation will be beneficial; it may equally be damaging. We must look at our motives in proposing this: will it make us look better or enhance our prestige, will it prevent litigation, and will we be acting, turning our casualty into the "Casualty" of the television?

I feel that perhaps being able to see from a distance through the doors may help, but to be intimately involved in the thick of organised chaos may be damaging, indeed callous. For if we are to care for individuals we must prevent post-traumatic mental illness and the only preventive measure is non-exposure.

Exposure may help grief, but it may not. It may create traumatic neuosis and delay the grieving process, or require more medicalisation to deal with not only the loss, but the traumatic images related to that loss. The key seems to be aiding bereavement without medicalising it.

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1 Mitchell MH, Lynch MB. Should relatives be allowed in the resuscitation room? J Accid Emerg Med 1997;14:366–9.

Should relatives be allowed in the resuscitation room?

ERROR—Mitchell and Lynch reported that accident and emergency (A&E) "staff felt the least experience in dealing with resuscitations and distressed relatives were likely to be opposed to relatives being present in the resuscitation room". Concerns about the design of this study led us to question their results. The small sample size (n=81) may be sufficient to estimate the overall proportion in favour of permitting relatives in the resuscitation room. However subgroup analyses based on such small numbers in each subgroup (for example 10 nurses and eight house officers) must be interpreted with caution. The statistical test used is not specified.

The validity of grouping all nurses together ignoring grade or experience must be questioned. We also believed the questionnaire to be a source of bias as it stated the authors' belief, their interpretation of the evidence, and was not anonymous. To test the questionnaire we repeated the study using the questionnaire wordingly randomly allocated to nurses in five A&E departments. Our first questionnaire used Mitchell and Lynch's wording; the second simply stated "I would like to know your opinion on relatives being present in the resuscitation room during cardio-pulmonary resuscitation. This is an anonymous questionnaire".

A total of 196 questionnaires were distributed, 99 (50.6%) were of the first type. An overall response rate of 54.1% was achieved. The response rate of 63.9% for the second questionnaire was higher than that for the first questionnaire (44.4%) (χ²=7.48, P=0.01). Although a greater proportion of respondents to the first questionnaire were in favour of allowing relatives to be present than for the second questionnaire this difference was not significant (table 1).

Table 1. Nurses in favour of relatives being present in resuscitation room; results are number (%)

| Questionnaire | Yes (%) | No (%) | Total |
|---------------|---------|--------|-------|
| First         | 37 (84.1) | 7 (15.9) | 44 |
| Second        | 48 (77.4) | 14 (22.6) | 62 |
| Total         | 85       | 21      | 106   |

Overall 85 (80.2%, 95% confidence interval 71.1% to 87.1%) of the 106 nurses who responded reported that they felt relatives should be present. This more robust estimate, than the 90% previously reported, confirms that the majority of nurses are in favour of relatives being allowed in the resuscitation room.

We believe the results of our small study demonstrate the design of Mitchell and Lynch's questionnaire is unlikely to have had a significant influence; however, their sample size is insufficient to enable recommendations to be made. Future analyses should have sufficient respondents by subgroup and should collect information on confounding factors such as age, sex, and years since qualification. These factors are necessary to determine whether the observed differences are real or artefactual. The presence of relatives in the resuscitation room is not a simple issue. Anecdotal reports and the impressions of family members are insufficient evidence of benefits to relatives. It is possible that the adverse effects for some individuals may be extreme and new recommendations should be supported by evidence.

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The authors reply

We welcome the responses to our paper and welcome the opportunity to correct some misunderstandings regarding our research on the matter.

The letter from Dr Matthew Cooke et al involves a restrictive study involving A&E nurses only and not all members of hospital staff likely to be involved in the A&E department. The number of respondents in their study was no greater than in ours but I agree that because ours was a more heterogeneous group, each subgroup was relatively small.

We did not ignore grade or experience of our A&E nurses. They were all above grade or above with at least four years of A&E experience and all had extensive experience in resuscitation including training, and they did not feel distressed relatives. That our forms were not anonymous helped in chasing up unreceived forms. I note that there was no significant difference in responses to either of their differently worded questionnaires and that both these figures mirrored ours. Whether 80.2% is more "robust" than 90% is debatable.

We are disappointed by the perception that we used our recommendations on the basis of anecdotal and other soft evidence. As we stated in our paper, it is our strong belief that before recommendations could be put into place, important measures must be undertaken:

* Rigorous analysis of opinions of staff and relatives, both before and after the resuscitation (ongoing for some months afterwards)
* Weekly resuscitation training sessions with moulage including one person taking the role of the relative and one the nurse accompanying the patient.

Dr Palmer in his letter adopts a paternalistic approach. Post-traumatic stress can be avoided by preventing exposure to both natural and unnatural disasters but they happen and this is unavoidable. Once the disaster has happened it may be too late but even then bereavement counselling has been standard in many hospitals for some years. It is in the context of the evolving disaster that if appropriate guidance and support are given, that the grieving process may be alleviated somewhat. When a child is dying in hospital we as carers have the nerve to prevent the parent from being present during the final resuscitation in the name of preventing post-traumatic stress I think not. Preventing distress is laudable but assisting people's grieving by offering them the opportunity of witnessing the resuscitation may be beneficial. The suggestion that we would be willing to enlarge our prestige by carrying out work is distasteful, offensive, and untrue.
There are some important points to this letter, however, particularly regarding what is referred to as the non-medicalisation of bereavement.

We are ignoring our duty as professional carers if we do not concern ourselves with the imminently bereaved and are just brushing under the carpet something we find difficult to deal with. Having drawn from our responsibility to bereaved loved ones, we invite relatives, without coercion or callousness, into the resuscitation room and give information in a compassionate way. Infringement of autonomy occurs when a relative or patient is deprived of the information he or she needs for autonomous decision making. It is unacceptable medical paternalism to withhold information in the fear that it will cause the patient or relative harm.

1 Mitchell MH, Lynch MB. Should relatives be allowed in the resuscitation room? J Accid Emerg Med 1997;14:366-9.
2 Adams S, Whitlock M, Higgs R, et al. Should relatives be allowed to watch resuscitation? BMJ 1994;308:1687-92.
3 Hartace SA, Swerw D. Family presence during cardiopulmonary resuscitation: Foote Hospital emergency department's 9 year perspective. J Emerg Nurs 1992;18:104-6.

Anterior glenohumeral dislocation

EDITOR,—I would like to make a few comments on the very informative article by A Gleeson on shoulder dislocation.1 I am one of the many people who reduce shoulder dislocations without injection of drugs but I do not choose this method for physician convenience. It is possible to achieve pain free reduction of the dislocation within a few minutes of the patient's arrival in the accident and emergency (A&E) department without the use of injected drugs. It simply needs explanation, reassurance, a quiet room, use of a simple relaxation or hypnosis technique, and gentle manipulation.

Relaxation reduces muscular spasm and therefore pain. Entonox given before manipulation process relaxes the patient.

The fact should be emphasised that most dislocations can be reduced without use of force and that traction is not necessary. The patient should be induced of this as it helps them to relax. It may take 10 minutes of slow movement to achieve reduction but in a relaxed and confident patient this procedure can be pain free.

It also means that an early attempt at reduction can be made before radiography is considered: there are no complications of slow gentle movement. If the patient is clearly in discomfort then the attempt is stopped and the traditional method used.

I would like to point out that D and E in fig 2 are in the wrong order.

Internal rotation is not part of the manoeuvre itself: it puts the arm into the position where it can be immobilised. If there is no resistance to internal rotation across the chest then reduction has been achieved. If there is resistance then pain and then the dislocation persists.

Can I suggest that the gold standard for shoulder dislocation is reduction:

- Without sedation
- Without injections of potent drugs
- As soon as possible after arrival in the A&E department
- Without further damage because force is not used
- Without the complications of benzodiazepines or opiates necessitating admission.

This is achievable: my own experience is that at least half of shoulder reductions can be done this way once the basic techniques become familiar. The success rate improves with practice, faith, and confidence.

I wholeheartedly endorse the view that reduction of shoulder dislocation should be a distress free experience and that force should not be involved but disagreed that "gold standard" means use of potent drugs.

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1 Gleeson AP. Anterior glenohumeral dislocation: what to do and how to do it. J Accid Emerg Med 1998;15:7-12.

The authors reply

I agree with Mr Lanning who it is indeed possible to achieve a relatively pain free reduction of a dislocation within a few minutes of the patient's arrival in A&E without the use of injected drugs by encouraging the patient to relax and to avoid sudden painful movements of the arm during dislocation. As a minimum I would recommend that all patients should be offered a trial of Entonox which will certainly facilitate the reduction process in the majority of cases. It is probably unwise to attempt reduction of an anterior glenohumeral dislocation without prior radiography as there may be a medicolegal battle over whether a fracture evident on a post-reduction film was present before reduction or occurred as a result of the reduction manoeuvre. The only circumstance where I would reduce an anterior dislocation without prior radiography would be in recurrent dislocators who have not fallen onto the arm and who sustained the dislocation with a combination of simple abduction and external rotation.

Do we need to be propped up with protocols?

EDITOR,—Stedman's Medical Dictionary defines protocols as... "...a precise and detailed plan for the study of a biomedical problem or for a regimen of therapy."2 Clinicians argue against protocols but seemingly their number is increasing every day. We wondered how many protocols could be drawn up for an accident and emergency (A&E) department. Using the index of the Cambridge Textbook of Accident and Emergency Medicine as a list,3 we selected protocols based on symptoms, signs, diagnoses, and therapeutic modalities relevant to British A&E departments.

We excluded conditions which are rare and not serious, administrative and local protocols, tropical diseases, and specialist conditions, for example Salter-Harris fracture classifications. We did not subdivide every major diagnosis, for example atrial fibrillation was not divided into acute and chronic. We did not consider protocols for the patient without an established diagnosis.

Four hundred and two potential protocols were identified of which 280 were deemed essential for every department.

While protocols may enhance quality of care, save time, make medical practice more focussed and scientific and reduce litigation, they may also produce more "cookbook" type medicine, inhibit free thinking, and make deviation from protocols open to litigation. Will delay in initial treatment due to protocol consultation jeopardise a patient's critical condition? Will it be possible for a junior doctor, or even a senior one, starting in the A&E department to study and remember all protocols and practise accordingly? By practising protocol based care in the A&E department are we not admitting that training, experience or supervision (or all three) are lacking?

The results of our survey, because of the large numbers of protocols involved, suggest protocol based emergency care will be difficult. It is therefore even more important that training is improved and supervision really available in A&E departments.

CS "gas" is not a gas

EDITOR,—The case report by Breakeall and Bodiwala usefully highlights several dangers of CS.1 However, by constantly referring to the agent as a gas they reduce the logic of many of their arguments. CS is a solid (melting point 94-95°C), though it may behave as a gas when dispersed as a fine powder from a pyrotechnic device. In Britain, however, CS is deployed dissolved in a solvent. When the solvent has evaporated, solid crystals of CS remain and may be deposited on the skin. This is usually the situation when the patient reaches hospital. Fanning with air, wiping exposed areas with dry tissue, and removal of clothing will be the most effective remedies. Clearly this would not be appropriate or adequate decontamination after exposure to a gas. By using the term CS and not calling it CS gas, people will understand the logic behind the emergency care of exposed victims.

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The authors reply

We agree entirely with Professor John Henry's comments that CS "gas" is not a gas, and reference to this fact was made in the discussion.1 We used the term CS gas due to the popularity and widespread use in the medical literature, not as a description of its chemical properties. We made the point that fanning with air (electric fan) caused contamination of the accident and emergency department and CS powder (crystals) converting to a solution on the surface of the clothing, managed by eye irritation rather than air currents.2

1 Breakeall A, Bodiwala GO. CS gas exposure in a crowded night club: the consequences for an accident and emergency department. J Accid Emerg Med 1998;15:56-7.
2 Yih JP. CS gas injury to the eye. BMJ 1995;311:276.

Fire

EDITOR,—On Sunday 5 October 1997 at 3.00 pm we were working in our emergency department at the Derbyshire Royal Infirmary, Derby. The fire alarm sounded and we completely evacuated the department into the car park. We quickly sent one very ill patient to...