DEAR SIRS

The issues to which Drs Kerwin and Lewis draw attention were fully discussed in correspondence in the *Journal*, last January; no additional matter of substance has been raised about them since then.

Although your correspondents make the statement that the editorial standards of the *Journal* were compromised by the publication of Supplement No. 3, they do not provide any supporting evidence for this view.

The allegation that "The same symposium was also published as a supplement by another journal (Silverstone, 1989)" is entirely untrue, as can readily be confirmed. Nor is it correct that Altamura *et al* (1988), which appeared in the supplement, "merely pooled data from two previously published clinical trials". The purpose of that paper was to provide a scientific discussion of problems relating to dosage schedules, using the trials in question as illustrations; that material had not appeared previously, and was a valid publication in itself.

In spite of their extensive discussion of 'redundant' publication, Drs Kerwin and Lewis give no example relevant to this Supplement, except for Wernicke *et al* (1989). That clearly appeared *later*, and is not a matter for which this *Journal* has any responsibility; any problem about it should be discussed with the appropriate editor. This *Journal* has not and will not condone practices such as dual publication, either in supplements or any other form.

The reference to "drug company supplements" is in any case misleading. In the case of Supplement No. 3, 45 pages of text were unrelated to any particular compound; the rest consisted of objective scientific information about fluoxetine, which is of important concern to the international professional community. No pharmaceutical company had any influence over the selection of papers, from a large number given at the relevant meeting, and their editing was entirely under the control of the *Journal*.

"Receiving money" is a phrase calculated to arouse distaste, by implying that something discreditable has been done. As I have pointed out in a previous letter (*Journal*, July 1989, **155**, 126) the surplus from publications is an increasingly important contribution to College income; without it, the College's activities would have to be seriously curtailed. We "receive money" from journal subscriptions, sale of books and supplements, advertisements, inserts, sale of reprints, and copyright or translation rights; Supplement No. 3 does not represent any deviation of principle from what has been done for many years in that way and which had not aroused criticism.

Any policy may be "potentially damaging" if carried out irresponsibly, inefficiently, or without observing accepted standards; no such circumstances have occurred in the case of our *Journal*, and I do not intend that they should occur in the future. Publication of supplements has followed the policy agreed by Council, and I have been heartened by the many expressions of support for them that I have received from colleagues.

HUGH FREEMAN

Editor
British Journal of Psychiatry

Attendance of health authority officers at Consultants' Advisory Appointments Committees

DEAR SIRS

It is disappointing that in recent months the College has twice reiterated its apparently strong view that managers should not be members of Consultant Advisory Appointment Committees (*Psychiatric Bulletin*, February 1989, **13**, 104 and Comments of the Royal College of Psychiatrists on the NHS White Paper 'Working for Patients' (*Psychiatric Bulletin*, July 1989, **13**, 385–389). Can at least one member of the College strongly disagree with this opinion for a number of reasons?

I am in little doubt that the local Mental Health Unit Manager is likely to have a much better idea of the nature of the post which is being appointed to than a number of the non local consultants on the Appointments Committee. I would go further and suggest that the presence of senior nurse, or at least a senior representative of the clinical non medical staff, would also be a valuable member of Consultant Appointments Committee as an involved colleague who will know the needs of the service.

If we had such a system, a pay-off would be that we should expect medical representation on senior management, nursing, psychology, etc. appointment committees. Frequently we are quite reasonably excluded from such appointment committees on a tit for tat basis.

Finally, to suggest, as the College's comments on 'Working for Patients' does, that the presence of a manager can lead to "serious distortion of the selection process" throws a very poor light on those psychiatrists present who apparently cannot stand up to the views of a forceful manager.

The whole tenor of these statements is defensive, even paranoid, and wholly out of tune with those parts of the College which are trying to move towards good multidisciplinary working relationships.

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In the wake of Hillsborough

DEAR SIRS

In the wake of the Hillsborough tragedy, in which 95 Liverpool football fans perished, the experience

of one Liverpool hospital casualty may be of interest.

Broadgreen Hospital is one of the three major hospitals providing acute care for Liverpool. Although the disaster itself occurred in Sheffield, in the first two weeks after the event Broadgreen Casualty saw 46 people who had been present on the terraces at Hillsborough on 15 April 1989.

The majority (27) presented at the weekend (15 and 16 April). Twenty patients presented because of crush injuries to their chest, for which they were given either ibuprofen or paracetamol. There were two patients with broken fingers, one with a broken foot and one case of broken ribs.

In their notes casualty officers described ten cases with co-existing anxiety, two with tension headaches, two cases of an acute panic attack and five cases presenting with co-existing low mood. Only two cases presented with low mood alone. Both these were referred to psychiatry and given out-patient appointments. The two cases referred subsequently conformed to the DSM-III-R criteria for post-traumatic stress disorder (309.80).

The psychological manifestations of distress in these casualty attenders were largely dealt with by sympathetic reassurance and by giving out the number of an emergency social services help line. Two patients received two-day courses of benzodiazepines. A referral to a psychiatrist occurred only in a small minority of cases.

The proportion of patients with psychological distress increased with time after the event, and it is likely that with this elapse of time the number of psychiatric referrals of post-traumatic stress disorder (PTSD) from GPs and social services will also increase.

With the prevailing current opinion among psychiatrists that the disabling PTSD is a 'physioneurosis' with a possible imbalance between noradrenaline and opioid release in the area of the locus coeruleus (Burges Watson, Hoffman & Wilson, 1988), there is a case for even earlier psychiatric referral of these victims, who may be participants in the disaster or indeed their rescuers (Taylor & Frazer, 1982).

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References

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TAYLOR, A. J. & FRAZER, A. G. (1982) The stress of post-disaster body handling and victim identification work. *Journal of Human Stress*, **4**, 4–12.

DEAR SIRS

The day after the Hillsborough disaster of 15 April 1989, 23 of 31 survivors in the Royal Hallamshire Hospital were seen and counselled by a team of volunteer social workers. One patient had returned to Liverpool before the social worker arrived on the ward, and seven were too seriously ill to be seen so soon.

The age range of the patients seen was 16–47, average age 24. All were male. Most of the (crush) injuries were minor, ten patients being discharged on Sunday 16 April 1989, and a further nine patients the following day. The patients were dispersed throughout the hospital in seven different wards.

The seven workers were hospital-based, familiar with the hospital, and familiar with seeing patients in an in-patient setting, as most had worked on the overdose team. They were working a shift system organised by the principal social worker who was co-ordinating social work activities at the Hallamshire, but liaised directly with the duty registrar in psychiatry (myself) when they had seen their allocated patients.

All the survivors were willing to talk to the social worker. The duration of the interviews ranged from ten minutes to one and a half hours. In some instances, counselling was awkward – for example, one teenager had spent most of the morning (very productively) with a clergyman, had then been interviewed extensively by the media, had been visited by Margaret Thatcher, and was surrounded by members of his family; going through the story again seemed unhelpful. Other individuals found counselling more constructive; some were able to cry for the first time, some found it useful to describe their experiences in detailed chronological order (when previously they had just described snatches of events with other survivors, and medical and nursing staff). Most had thought they were going to die, several described near-death experiences. All had witnessed others dying and dead, and several had lost friends or relatives.

Each was encouraged to express his emotions, and told of some of the reactions they might expect. Each was given the telephone number of Liverpool Social Services or the Helpline Number, and encouraged to contact it as necessary. Twelve had no further specific follow-up, though nine were seen subsequently on one or more occasions by the same social worker. Two who had identifiable problems but were returning to Liverpool shortly were referred direct to Liverpool Social Services for further counselling.

'Counselling' is a non-specific term reviled by the two consultant psychiatrists concerned with the aftermath of the Lockerbie disaster (McCreadie, 1989; Pearson, 1989) (though there local people and bereaved relatives were offered counselling, not survivors). Further, there is no evidence that counselling