such pragmatism among those doctors who do not have a moral objection to non-medical caesarean section.

Contributors: SFM is the sole author of this paper. She initiated the research, designed the protocol and the data collection instruments, conducted the in-depth interviews, coded and analysed the qualitative and quantitative data and wrote the paper. Fanny Serani (lecturer at the University of Chile) participated in the piloting of the survey instrument and conducted the postnatal survey interviews. Mary Ann Elston (senior lecturer in the department of social and political science at Royal Holloway College, University of London) discussed core ideas and commented on an early draft of the paper. Angie Wade (senior lecturer, Institute of Child Health) provided statistical advice.

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Presence of relatives during testing for brain stem death: questionnaire study

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In brain stem death, where the body remains warm and pink and has a pulse and a chest that rises and falls, relatives may have difficulty accepting that the patient has died. It has been suggested that if relatives witness tests for brain stem death being performed then this may improve their understanding that death has occurred.[1] But, however careful the explanation, any potential benefit to relatives of observing testing for brain stem death may be offset by doubts caused by the movement of limbs during testing (due to spinal reflexes), which often occur when testing for cranial nerve activity (shown as facial movement) by using painful stimuli.

Despite these concerns, we occasionally allow relatives to observe testing for brain stem death because it may help some families to understand that the patient has died. As there is no evidence to support or refute this practice, we undertook a survey to establish current practice in intensive care units in the United Kingdom.

Subjects, methods, and results

After obtaining ethical approval, we telephoned 28 neurotrauma intensive care units to identify which senior staff would usually be involved in testing for brain stem death. We sent a questionnaire to the 147 consultants and 167 senior nurses identified; the response rate was 79% (116/147) for consultants and 77% (129/167) for senior nurses.

Overall, 32% (37/116) of consultants and 42% (54/129) of nurses had experience of relatives' presence during testing, and 69% (63/91) of these felt that this was helpful for relatives (table). Nurses were more likely than doctors (84% *v* 53%) to believe that witnessing the tests would help relatives to accept that the patient had died, and 48% thought that relatives may gain comfort from being present.

The major potential problems were cited as spinal reflexes (85%) and dealing with the relatives' distress

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Responses of consultants and senior nurses to questionnaire on the presence of relatives during testing for brain stem death*

Item	No (%) of consultants (n=116)	No (%) of senior nurses (n=129)
I have invited relatives to be present at testing for brain stem death	22 (19)	29 (23)
I have been asked by relatives if they could attend testing for brain stem death	35 (30)	54 (42)
I have allowed relatives to attend testing for brain stem death	37 (32)	54 (42)
In my experience, attending testing helped the relatives	23/37 (63)	40/54 (74)
The presence of relatives would affect my performance	18 (16)	8 (60)
With appropriate support for relatives, I would be more willing to allow presence of relatives	35 (30)	76 (59)
If the patient was a child it would make no difference to allowing relatives to be present	81 (70)	79 (61)
Most frequently cited problems associated with the presence of relatives:		
Spinal reflexes	97 (84)	111 (86)
Handling relatives' distress	84 (72)	88 (68)
Extra nurse needed for support	54 (47)	47 (36)
Verbal interference from relatives	35 (30)	47 (36)
Most frequently cited benefits associated with the presence of relatives:		
Relatives more able to accept that patient has died	61 (53)	108 (84)
Relatives gain comfort from being present	52 (45)	65 (50)

*Complete findings and questionnaire are available on the BMJ's website.

bmj.com

The questionnaires completed by the consultants and senior nurses appear on the BMJ's website

(70%). Forty five per cent of respondents said they would be more willing to allow the presence of relatives if adequate support was available, particularly careful explanation and a dedicated person able to support the family.

Comment

Two thirds of consultants and nurses who had previous experience of relatives being present during testing felt that the relatives had benefited from this. The diagnosis of brain stem death is extremely stressful for relatives. Relatives have refused to allow ventilation to be discontinued, leading in one case to a delay of 48 hours.[2] Public confusion remains between brain stem death and the "persistent" (not "permanent") vegetative state, when patients rarely regain consciousness.[3]

Relatives who observed cardiopulmonary resuscitation showed improved psychological outcome after three months.[4] By contrast, testing for brain stem death is more controlled, with time to prepare relatives for what they will observe. It is possible that allowing relatives to be present may help them to understand the diagnosis and may assist the grieving process. Witnessing the first disconnection test might help relatives "understand the difference between breathing and being breathed" and may help them "accept that a declaration of death is imminent."[5] Coolican said that relatives should be offered a choice about witnessing testing for brain stem death and that by "participating … in dying or death" relatives might benefit in the control thus exercised.[1]

However, testing for brain stem death was described by some respondents as "macabre" and "harrowing" and will often seem that way to relatives' families. Relatives observing testing must be capable of understanding the importance of the apnoea test and that movements that seem purposeful and involve the neck as well as the hands and the limbs are in fact only spinal reflexes. Continual explanation is essential.

At present, a minority of doctors and nurses invite relatives to observe testing for brain stem death. More may consider doing so in the future. Whether this is beneficial to these families remains to be seen. The problems associated with the presence of relatives at testing for brain stem death should not be underestimated.

We thank Andrea Cook for organising the questionnaire survey.

Contributors: LC and SB had the original idea. All contributors participated in the study design, interpretation of findings, and writing of the paper. JG performed the statistical analysis and JH the qualitative analysis. SB will act as guarantor.

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Choosing a collaborator

The project looked promising. We planned to determine, using a rat model, whether chemotherapy-induced damage to an endocrine gland could be modified by endocrine manipulation induced before and during chemotherapy. We had an excellent team—Gerry, Ian, Barry, and myself (Steve)—and everyone was making a significant contribution. This was my first real attempt at being involved in research that tested a hypothesis as opposed to more clinically orientated observation. I felt that it represented a genuine step forward in my research profile and my hopes were raised further when within less than two years the results of the study supported the initial hypothesis.

So it was time to publish our findings and, as a mere clinician involved in basic science experimentation for the first time, I chose to rely on the experience of my senior colleague from the medical school. He chose a high impact American journal, the referees made complimentary remarks, and the article was accepted without fuss. The only slightly unusual aspect was the journal's request for the Christian names of all authors. Previously I had only published in journals that used surnames and initials but I could not see any problem with the addition of Christian names.

The proofs were sent to the senior scientist for checking and so I was not aware of the disaster about to unfold until the article appeared in print. This was going to be the big one, big enough to make my reputation. After months of waiting I sat at my desk and scanned the title page and authorship: Gerry, Ian, Steve, and Barrington. *Barrington*. I was scarcely able to take in the full horror of what lay in front of me. Barrington, what a name—everyone called him Barry. Why, oh why, did he have to be called Barrington? I knew immediately my chance of glory had gone. Who on earth is going to pay any attention to a Steve when there is a Barrington on the team sheet?

It was in the wee hours of the morning after my discovery of my collaborator's real name that I made the following resolutions about future collaborations: if you do not want unfair competition, never work with anyone with a double barrelled name, or with the second, third, or fourth, or even junior placed after his/her name. In fact never work with anyone whose Christian name contains more than five letters.

When you are thinking about possible collaborators, do not worry about intellect, motivation, capacity to see a project through to completion, writing skills, or even the grandeur of their CV. Just demand to see the birth certificate.

Whatever the various contributions of different authors, a Steve will never be noticed next to a Sebastian Montmorency or a Montague Kingsley the fourth, junior. The only alternative, apart from giving up, is a name change that provides you with an unforgettable moniker, but that is really risky and lays you open to the possibility that most potential collaborators will choose not to work with you.

Stephen M Shalet *professor of medicine, Manchester*

We welcome articles of up to 600 words on topics such as *A memorable patient, A paper that changed my practice, My most unfortunate mistake*, or any other piece conveying instruction, pathos, or humour. If possible the article should be supplied on a disk. Permission is needed from the patient or a relative if an identifiable patient is referred to. We also welcome contributions for "Endpieces," consisting of quotations of up to 80 words (but most are considerably shorter) from any source, ancient or modern, which have appealed to the reader.