
**What's happening in psychology?** E-mail news@thepsychologist.org.uk. We also welcome evidence-based analysis of current events (up to 1500 words). Contact the editor first on jonsut@bps.org.uk. Send reviews of research published in peer-reviewed journals (up to 400 words) to Dr Tom Stafford on tom@idiolect.org.uk. Staff journalist: Dr Christian Jarrett (chrber@bps.org.uk).

# London bombings trauma victims still being found

MONTHS after the suicide bombings that shook London on 7 July last year, psychologists working with the NHS Trauma Response Team are continuing to identify and offer treatment to people traumatised by that day's terrible events – not only those directly injured, but also witnesses, the bereaved and emergency responders.

By the end of January, the team had contacted 395 people using a brief 10-item trauma questionnaire delivered by post or telephone. This asks people whether they have had certain experiences twice or more during the past week, such as 'upsetting dreams about the event' or 'acting or feeling as though the event were happening again'. Two questions about depression and one about travel phobia were also included. Of those people screened, 117 have been referred on for psychological treatment, including trauma-focused cognitive behavioural therapy and eye-movement desensitisation and reprocessing therapy, as per the NICE guidelines for post-traumatic stress disorder published last year (*tinyurl.com/b6f6l*).

However, psychologist Mary Robertson, a member of the steering group overseeing the project, said that based on past research, of the approximately 4000 people affected by the London bombs, around 1120 are likely to have gone on to develop post-traumatic stress disorder. To continue identifying trauma sufferers who have yet to receive help, the project is using police witness lists, and is working with occupational health departments, the Health Protection Agency, the NHS Direct helpline, GPs, accident and emergency departments, and the media.

The response programme is a collaboration of various trauma services with welfare agencies, local government, emergency services and trauma experts. The London Development Centre for Mental Health is providing support and is helping to coordinate the project.

Robertson told *The Psychologist*: 'This is something new that will be evaluated so that we can learn how best to respond to mental health needs in the event of future major incidents.' Professor Chris Brewin at UCL is heading the evaluation of the project.

On a related note, as part of a three-year project examining crowd behaviour during emergencies, Dr Christopher Cocking and Dr John Drury at Sussex University are seeking people caught up in the 7 July bombs who are willing to share their experiences via an online questionnaire (*tinyurl.com/7c8zq*).

'The research takes the premise that current crowd models used by emergency planners are flawed in that they assume that large crowds of people are unthinking and prone to panic, and therefore cannot be trusted during any emergencies,' Dr Cocking told us (and see *www.bps.org.uk/tiny/n50dz5* for an article from the *Psychologist* archive). 'However there is very little evidence to support this "panic model", and studies of disasters over the last three decades have found that rather than descend into irrational, selfish panic in emergencies, cooperative and ordered behaviour within social norms is much more likely.'

It's hoped the research could lead to improved measures for the control of crowds. Dr Cocking again: 'To this end we have attracted interest from both local and national government and private sector organisations involved in crowd management. We have also done consultancy work for these bodies which has been very well received, and have also had contact from private sector groups interested in developing our virtual reality simulation [of crowd emergencies] as a training tool for the emergency services.' See *www.sussex.ac.uk/affiliates/panic* for more information. *CJ*

JESS HURD (REPORTDIGITAL.CO.UK)

**DEADLINE**

We welcome news items from members for possible publication; deadline for the May issue is **31 March**

# European citizens deliver proposals on brain science

ONE hundred and twenty-six citizens, nine languages, 72 hours, 75 support staff, and 48 translators and facilitators – the Europe-wide Meeting of Minds project (see News, December) culminated at a convention in Brussels on 23 January. The citizens panels from nine European countries had come together to share their recommendations for the future of brain science, marking the end of what's thought to have been the largest-ever public consultation on science.

After consulting with their countries' leading psychologists and neuroscientists, participating citizens agreed on 37 recommendations that organisers of the project hope will inform the European Union's forthcoming Green Paper on Mental Health, and the European Commission's Seventh Framework Programme, its principal instrument for funding research and development.

'Meeting of Minds is an important achievement, establishing that citizens' participation is not only possible but also highly desirable,' said Janez Potočnik, EU Commissioner for Science and Research. 'I'm convinced that this will contribute to more robust European policies.'

Breakthroughs identified by the project as being likely to raise ethical questions in the near future included the use of deep brain stimulation for treating mental illnesses like depression (with such powerful treatment, might it come to be seen as a social disease to be compulsorily treated, rather than as a personal medical problem?); the development of pacifying drugs that could be used to control behaviour; the use of cognitive enhancers with implications for fairness in tests, and the inevitable pressure on people to use them

to meet work demands; and genetic profiling. 'We ask for the explicit right of citizens to choose whether or not they want to receive early testing or be informed of an early diagnosis,' the citizens declared.

Amid concerns that advances in brain imaging could threaten individual privacy, another recommendation made by the citizens was that the police should not be allowed to use brain imaging as part of their investigations. Professor Axel Cleeremans, director of the Cognitive Science Research Unit at the Free University of Brussels, explained the rationale behind the recommendation: 'There is a genuine possibility that we might not be able to hide anything from others in the future,' he said. 'Methods for assessing brain activity will become sufficiently sophisticated that one will be able to find specific and reliable markers for recognition memory, lying and various emotional states.'

Other recommendations of interest to psychologists include a proposal that greater emphasis be placed on the prevention of mental illness; that efforts should be made to help people learn how to learn; that NGOs should be given extra help educating the public about the brain sciences; and that there should be greater clarification and education about healthy diversity and variation in populations. 'Public campaigns and TV programmes should be developed to provide people with better information to prevent stigmatisation. There need to be more experts whose fields are education and school psychology,' the final report says. *CJ*

❏ *The project's final proposals can be read in full at www.meetingmindseurope.org.*

## PSYCHOLOGISTS BEST IN STOCKS

AN investigation into share-dealing behaviour has shown that psychologists make particularly skilled dealers on the stock market. Researchers from the Bank of England, the corporate consultants McKinsey and the universities of Bonn and Heidelberg used an internet share-dealing game with real cash prizes to test the buying behaviour of 6500 participants, including psychologists, economists and physicists. On average, the psychologist participants managed to earn three times as much as physicists and economists, largely because they seemed to be aware of how the irrationality of other people's buying behaviour was affecting share prices.

'Psychologists tended to decide against buying shares precisely when a lot of other players had bought them,' explained co-researcher Dr Andreas Roider of the University of Bonn's Economics Department. 'They were more sceptical about the prospect of a stock when its price was rather high,' he told *The Psychologist*. 'In such situations they frequently preferred to invest in what seemed to be cheaper investment opportunities. As the higher profits they earned document, they seem to have had a better grasp that recent trends might to a certain degree have been driven by irrational behaviour of earlier investors.' *CJ*

**Psychologists have a better understanding of investors' irrational behaviour**

❏ *The findings are published in the December issue of the* American Economic Review.

### *SOCIAL SCIENCE WEEK*

FOR the fourth year running the ESRC is holding Social Science Week. But this year for the first time it has been scheduled to coincide with National Science Week, 10–19 March 2006. The event is intended to give an insight into some of the country's leading social science research and its influence on our social, economic and political lives – both now and in the future.

❏ *For details see the website at www.esrcsocietytoday.ac.uk/week.*

## RESEARCH FUNDING NEWS

The Experimental Psychology Society (EPS) in collaboration with the British Association for the Advancement of Science (BAAS) awards an **Undergraduate Project Prize to the best final-year undergraduate project in experimental psychology** submitted from a UK psychology honours degree programme. To be eligible, students must be registered on the final year of a BPS-accredited UK honours degree in psychology and be intending to pursue postgraduate studies in psychology. The closing date for nominations is 10 July 2006.

❏ *For further details contact Karen Lander, BAAS Psychology Section Recorder, e-mail: karen.lander@psy.man.ac.uk or see the EPS website www.eps.ac.uk/grants/epsba.html.*

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The American Cancer Society is offering 12-month-long **international fellowships for beginning investigators and clinicians who are at the early stages of their career**. The fellowships aim to foster the flow of knowledge, experience, expertise and innovation between countries. Preference for funding is given to candidates who propose to conduct **cancer research projects into the pre-clinical, clinical, epidemiology, psychosocial, behavioural, health services, health policy and outcomes and cancer control**. $40,000 is available for travel and stipend support. The closing date for applications is 1 December 2006.

❏ *For further details see the American Cancer Society website tinyurl.com/dxyg9.*

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The Help the Aged New Investigator Awards are available for researchers planning to make a long-term career in ageing research. They provide short-term flexible funding for salary or consumables, or to enable the applicant to free up time for research. **Eligible research areas include stroke and neurodegenerative diseases (including Alzheimer's), cognitive decline and sensory loss**. Funding of up to £50,000 is available. The closing date for applications is 14 July 2006.

❏ *Further details: http://research.helptheaged.org.uk.*

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The **Health Foundation's Leaders for Change award scheme** aims to equip experienced health professionals with the necessary skills and knowledge to lead change and achieve lasting improvements in the quality of patient care. It is a competitive scheme open to all healthcare professionals, including clinicians and managers, leading service improvement at a local level. Applicants must have a discrete area of work or project in which they have a lead role to develop during the period of the award. The award provides **funding for attendance at the Change Agent Skills Programme at Lancaster University Management School**, replacement staff costs to facilitate attendance at the course and assistance for travel, subsistence and other training costs. The closing date for applications is 3 May 2006.

❏ *To find out if you are eligible for the award contact the Foundation on Tel: 020 7257 8000 or visit their website www.health.org.uk/ourawards/leaders.*

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**For a list by deadline date of current funding opportunities go to www.bps.org.uk/tiny/epv8h8.**

**Funding bodies should e-mail news to Elizabeth Beech on elibee@bps.org.uk for possible inclusion.**

# Physical therapists providing psychological support

FROM a survey of 354 physiotherapists, chiropractors and osteopaths, Dr Tamar Pincus at Royal Holloway, University of London and colleagues found that at least 10 per cent of physical therapy practitioners continued long-term treatment with patients, even after three months or more without demonstrable improvement. Follow-up interviews with 42 of the surveyed practitioners suggested this proportion was an underestimate, and revealed how many physical therapists see it as their responsibility to provide psychological support and health advice to patients.

Quotes from interviews with the physical therapists demonstrated how wide-ranging they perceived their responsibilities to be. 'I am actually going to help her through her time of need,' one physiotherapist said of a long-term client. 'I feel as if there is a missing link, somewhere in that jigsaw something hasn't fallen into place and…I don't think we should be focusing on the pain,' said another.

Despite international guidelines for the treatment of lower back pain in primary care recommending that patients be referred back to their GP in the absence of any improvement, it was also clear from the interviews that the physical therapists were unhappy to discharge patients, and were uncertain about what would happen to their clients once they had left their care. 'You can actually upset patients by trying to get them off treatment,' an osteopath explained. 'She wants the service and I cannot deny her that service,' said a physiotherapist.

In light of the findings, lead researcher Tamar Pincus told *The Psychologist* her team would like to see cognitive behaviour therapy (CBT) techniques taught to physical therapists in the early years of their training, under the careful supervision of trained chartered psychologists. They would also like CBT training introduced under supervision at postgraduate level, as part of physical therapists' continuing professional development. 'Not all physical therapists would opt for these, but it would create an excellent body of "experts" within the professions,' Pincus said.

'We also believe that training should include an aspect of acceptable discharge, so the clinicians learn to contract to end treatment in a way that is acceptable to clients,' Pincus added. 'Our study shows that many clinicians find that avoiding conflict by continuing to treat is easier than confronting the patient. However, a training component informed both by clinical psychology and psychology of management should be able to assist both patients and clinicians to create an empowering contract that enhances self-management, without a sense of desertion or betrayal.' *CJ*

❏ *A report on the findings appears in the January issue of the* European Journal of Pain.

ROY PETERS (REPORTDIGITAL.CO.UK)

# Not so SureStart?

'SURESTART, I do believe, has made a real difference to people's lives' – that was Tony Blair's verdict on his government's investment of half a million pounds in 500 small, highly disadvantaged areas in England, aiming to give children aged up to three years a better chance in life (see *www.surestart.gov.uk*).

But early findings from the National Evaluation of SureStart (NESS: see *www.ness.bbk.ac.uk*) have been far more equivocal. Comparing 16,502 families in SureStart areas with 2610 control families on a raft of social, educational and health measures, NESS found only one modest improvement in child functioning – the three-year-old children of non-teen mothers in SureStart areas exhibited fewer behavioural problems. On parental measures, there was also just one modest improvement – mothers in SureStart areas were more accepting of their children's behaviour, and so slapped and scolded them less.

In some cases, the programme was associated with negative outcomes. For example, in SureStart areas, mothers with 36-month-olds rated their communities less favourably than mothers in control areas. And the children of teen mothers in SureStart areas showed more behavioural problems than equivalent control families. However, the NESS report recommends treating these early, cross-sectional findings with caution: 'Stronger grounds for drawing definitive conclusions about SureStart Local Programme (SSLP) effectiveness will exist once longitudinal data on the nine-month-olds and their families in SSLP areas who are included in this report are followed up at 36 months of age and thus have been exposed to SSLPs for a much longer period of time.'

However, Dr Stephen Scott, who directs a parenting research programme at the Institute of Psychiatry, King's College London, and heads the child antisocial behaviour clinic at the Maudsley Hospital, told us that in terms of immediate effects on the life trajectories of children born in poor areas, it was clear SureStart had not worked. 'Given such an appealing, visionary project and the apparent obvious goodness of the idea of getting in early, this is a painful conclusion to stomach,' he said.

MARK PINDER (REPORTDIGITAL.CO.UK)

**Tony Blair gives SureStart the thumbs up, but does it make a real difference?**

'The study was thorough, the measures adequate. Some have argued that improvements may show up later, but this has not reliably occurred in any previous prevention project where there was no initial effect,' he warned.

But Scott also told us that SureStart need not be a waste of time and money if lessons are learned and appropriate changes made: 'Firstly, specific aims are needed – locality goals were far too wide, including reduction of speech delay, teenage pregnancy and maternal depression, meaning resources got spread too thinly. Secondly, screen for need: even in the poorest areas, the majority of people are functioning quite well – resources should be allocated to those who most need them. Thirdly, use evidence-based interventions, not a mixed bag of effective and ineffective ones. Fourthly, insist on weekly supervision of workers to ensure fidelity to the therapy and a high level of skill – training staff this way is emerging as key to getting reliable change. Fifthly, use simple evaluations locally as you go along, and modify interventions in the light of this. Finally, employ high-quality senior management to coordinate elements – SureStart forbade this, yet the evidence is clear it is crucial.'

Dr Scott concluded: 'If lessons are learned, then SureStart will have been a pioneering step towards giving children fairer opportunities. If, however, people carry on in the same way, or quietly shelve it, it will have been a failure.'

Professor Edward Melhuish, at the Institute for the Study of Children, Families & Social Issues, Birkbeck, who heads the NESS assessment, declined to comment at this stage. *CJ*

❏ *National Evaluation of SureStart early findings: www.surestart.gov.uk/_doc/P0001867.pdf.*

## WEBSITES

***www.edge.org/q2006/q06_index.html***

Leading scientists answer the question 'What is your dangerous idea?'

***www.utdallas.edu/~kilgard/lectures.htm***

Online neuroscience lectures

***http://bps-research-digest.blogspot.com***

The latest from the Society's Research Digest

**If you come across a website that you think would be of interest to our readers, let us know on *psychologist@bps.org.uk*.**

# Praise pays

JOHN HARRIS (REPORTDIGITAL.CO.UK)

A THREE-hour training package that encourages teachers to focus on praising pupils who are behaving well in class, rather than on admonishing naughty pupils, has been shown to successfully improve class discipline, according to research presented at the BPS Division of Educational and Child Psychology's annual conference in Bournemouth.

Dr Jeremy Swinson and Professor Alex Harrop of Liverpool John Moores University, together with educational psychologist Richard Melling, trialled the training programme on 19 teachers from six primary and secondary schools in Trafford and Salford. Before the training 54 per cent of teachers' verbal feedback to pupils was classed as praise, compared with 46 per cent as admonishment. After the training, they averaged 85 per cent praise versus 15 per cent admonishment. And crucially, 94 per cent of the pupils were deemed obedient after the training compared with 78 per cent before.

'Many teachers were unaware of the skills needed to deal with unruly classes and over-relied on telling pupils off, which in the long run has very little effect on the pupils' behaviour,' Swinson said. *CJ*

### *ART AND MIND FESTIVAL*

AN Art and Mind Festival 'Space, Architecture and the Brain' will take place in Winchester 10–12 March 2006. The event will consider space and our relationship to it through the sciences and the arts, from an evolutionary perspective to contemporary neuroscience, and through its use and expression in architecture and the arts.

❏ *For details: www.artandmind.org.*

# Sense about MRI scans

PSYCHOLOGISTS using magnetic resonance imaging (MRI) are being encouraged to show how important it is to their work, in the face of proposed legislation that threatens the technique's future.

In 2004 a European Union directive was passed that sets limits on occupational exposure to electromagnetic fields. These limits, when incorporated into UK law in 2008, will make many procedures using MRI illegal or very difficult. Leading scientists responded critically to the Secretary of State for Health, and in January a meeting was held with the Health and Safety Executive.

Tracey Brown, Director of the charity Sense About Science, told us: 'It was a shock to discover that the scientific justification for this directive was even more tenuous than initially thought. The limits turn out to be based on the deliberations of a group of scientists who discussed weak electric fields some time ago. This group, on finding out the use of their deliberations, have written to HSE and others to indicate that guidelines could not be founded on that discussion.

'The EC Directorate for Employment, Social Affairs and Equal Opportunities, is now considering meeting with European representatives of scientists, manufacturers and clinicians to review the problem. This would be a great development and a sharp turnaround from the Commission's earlier dismissals of the clinicians' complaints. We would encourage all the clinical groups and research scientists who use MRI to contact their European representative bodies to ensure that they inform the Commission of the impact of restricting MRI on particular areas of healthcare and R&D across Europe.'

The government's Science and Technology Committee will also be looking at the topic as part of an inquiry into the government's use of scientific advice (including the social sciences). It will test the extent to which policies are 'evidence-based'. *JS*

❏ *For more information see www.senseaboutscience.org.uk/MRI.*

## EXAMINERS SOUGHT

High-quality examiners are crucial to the success of the GCSE and A-level system, and boards are currently recruiting for 2006.

In 2004 a MORI survey found that more than eight out of ten examiners, moderators or markers said they were satisfied with the role and nearly nine out of ten would recommend it to colleagues. Both new and experienced psychology teachers say that examining is a key aspect of their professional development, and a good way to learn while earning.

❏ *See www.examinerrecruitment.org for details.*

## RAE CRITERIA PUBLISHED

The Research Assessment Exercise (RAE) criteria and working methods by subject panels have been published, and are available at *www.rae.ac.uk/news/2006/criteria.htm.*

A period of consultation resulted in over 500 responses from higher education institutions, subject associations, learned societies, research councils and other bodies. Ed Hughes, RAE Manager, said: 'A number of changes to the criteria were made to ensure that the assessment would be consistent across related subject areas.' Sir Howard Newby, HEFCE chief executive, said: 'The criteria address a number of policy areas which are important to the funding bodies – for example, their commitment to equal opportunities; the full and fair assessment of applied research, practice-based research and interdisciplinary research; and the sustainability and vitality of the research base through the support of early career researchers.' *JS*

*The Society's free Research Digest service has over 18,000 subscribers. To join them, send a message to subscribe-rd@lists.bps.org.uk. Here's a sample, by the Digest editor* **CHRISTIAN JARRETT**.

# DO THERAPISTS IMPROVE WITH EXPERIENCE?

When choosing a therapist, you'd be forgiven for wanting someone with plenty of experience. But then you might well be unaware of all the studies that, to psychotherapy's embarrassment, have failed to find any association between therapist experience and the likelihood of a client getting better.

However, Scott Leon and colleagues have suggested that crude measures of therapist experience – such as 'years since graduation' – have rendered past research fundamentally flawed.

In their new study, they took advantage of a nationwide database of client outcomes collected over several years, to see if a client was more likely to get better if their therapist had previously engaged in therapy with someone demographically similar to themselves, and with similar problems.

From 2366 clients treated by 92 therapists, Leon's team identified 83 pairs of similar clients who had been treated by the same therapist. The researchers were specifically interested in whether, of the two clients in a matched pair, a therapist was more successful at treating the second of the two clients to come to them. As a control, 86 random pairs of clients were also compared. A client's improvement was measured according to data that both they and their therapist entered periodically onto the database.

Therapists did indeed tend to have more success with a client if they had previously treated someone similar, but only if the second client came to them within 15 to 75 days of the first. In contrast, therapists had no more, or less, success with second clients who started therapy between 75 and 720 days, or longer, after the first 'similar' client. The researchers said this suggests that 'therapists can make use of prior experience with future similar patients, as long as the subsequent patients enter treatment shortly after the initial patient'.

What about the implications for therapist training? The researchers said: 'If replicated, these findings could suggest that therapists gain from experience if they are allowed to treat similar types of patient in quick succession.' They added that the 'findings might provide support for a specialised training and practice model'.

Leon, S.C., Martinovich, Z., Lutz, W. & Lyons, J.S. (2005). The effect of therapist experience on psychotherapy outcomes. *Clinical Psychology and Psychotherapy, 12*, 417–426.

**Weblinks**
Abstract: *tinyurl.com/dxe5j*
Author: *tinyurl.com/bg978*

# MIND WHERE YOU SIT – IT MAY MAKE AN IMPRESSION

If you're going for a group interview, or if you want to make an impression in class, try to sit as centrally as you can – new research suggests observers tend to overestimate the performance of people positioned in the centre.

Priya Raghubir and Ana Valenzuela analysed the first 20 episodes of the quiz show *The Weakest Link* that appeared on American TV in 2001. The quiz involves eight contestants standing in a semi-circle with one player, 'the weakest link', voted off each round by the other players. Raghubir and Valenzuela found that players occupying the two central positions reached the final round 42.5 per cent of the time, and won the game 45 per cent of the time, whereas players in the two most extreme positions reached the final round just 17.5 per cent of the time, and won just 10 per cent of the time. In another study 22 students watched an episode of *The Weakest Link* and attempted to recall the performance of each player afterwards. This showed they tended to overestimate the performance of the central players but underestimate the performance of the peripheral players. When the participants were warned to pay special attention, their accuracy at recalling the central players' performance improved whereas their memory for the peripheral players remained unaffected. This is consistent with the researchers'

theory that observers pay less attention to people in the centre, assuming their performance will be superior because of where they're located.

In another experiment, 111 students were shown different versions of a group photo showing five candidates for a business internship arranged in different positions. The participants knew the candidates had similar abilities but still tended to choose the candidate in the middle of the photo they were shown. Afterwards the participants stated whether they agreed with the statement 'Important people sit in the middle of the table', and it became clear that it was only participants who agreed with that statement who tended to favour the internship candidate in the middle of the group photo they saw.

'We have identified a biasing cue in objective judgments: the target's position,' the researchers concluded. 'These results have implications for selection interviews and performance assessment tasks such as grading, auditions or any evaluation of individuals competing in groups.'

Raghubir, P. & Valenzuela, A. (2006). Center-of-inattention: Position biases in decision-making. *Organizational Behavior and Human Decision Processes, 99*, 66–80.

**Weblinks**
Abstract: *http://dx.doi.org/10.1016/j.obhdp.2005.06.001*
Author: *www.haas.berkeley.edu/faculty/raghubir.html*

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# Living donor liver transplants

*Liver transplants from living relatives will soon be a reality in Scotland.* **LESLEY MCGREGOR** *and* **RONAN O'CARROLL** *discuss some of the psychological issues.*

WOULD you agree to an operation where you gave 60 per cent of your liver to a sick relative? Next month, the Scottish Liver Transplant Unit (SLTU) will become the first NHS transplant unit in the UK to offer living donor liver transplantation (LDLT) to adults with serious liver disease. This groundbreaking treatment will offer a much-needed 'lifeline', as time spent on the waiting list may be significantly reduced.

Transplantation from a living donor is made possible through the liver's unique ability to grow back to its original size once it has been split. This is the case for both the part of the liver transplanted into the relative and the part that remains in the donor. LDLT was first developed in Japan where, for cultural reasons, organs from individuals who have died are not used. Over the past 10 years, some other countries in North America and Asia, and, in Europe, France and Germany have begun to offer LDLT as an alternative; in April, Scotland will follow suit.

LDLT with children has been carried out for some time, but in adult-to-adult LDLT a much larger part of the donor's liver is required and so the operation is more serious for the donor. Consequently there are some interesting psychological issues surrounding the procedure, and implications for both research and practice.

## An ideal solution?

As a result of low donation rates, patients can face a long wait for a new organ. Many patients consequently become too ill to go through with the transplant operation, or they die before a suitable organ is found. The shortage of donated organs from individuals who have died is a problem found in every transplant unit throughout the UK and beyond. In Scotland, between April 2005 and November 2005, 10 patients died while on the liver transplant waiting list. In addition, three patients became too unwell for transplant and had to be removed from the list. At the moment there are 23 patients on the Scottish list, anxiously awaiting news that a donated liver, from someone who has died, has been found and their liver transplant can proceed.

When asked in surveys, around 90 per cent of the general public agree that organ donation is 'a good thing'. But following the death of a loved one, less than 50 per cent of relatives agree to proceed with organ donation. Why? Loss of faith in the medical profession (perhaps following Alder Hey and Shipman)? Bad publicity associated with famous transplant recipients (e.g. George Best)?

Three out of four GPs believe that the UK should introduce an 'opt-out' organ donor scheme. In an opt-out scheme, organs from those who have died may automatically be removed and used to save the lives of those in need of transplants, unless the donor or their family specifies that organs may not be used in this way. The move, if adopted in the UK as it is in other countries, could dramatically reduce the death rate among those currently awaiting transplantation. However, proposals for an opt-out scheme have repeatedly been rejected in the UK.

BSIP PLATRIEZ/SCIENCE PHOTO LIBRARY

LDLT may seem like an ideal solution to the waiting-list problem, but this lifeline comes at a cost. The healthy donor has to go through a major operation with no personal physical benefit. The risk of death for the donor is estimated to be between 0.5 and 1 per cent – far higher than the risk of death in donating a kidney (0.03 per cent). In addition, the risk of complications arising from the operation is thought to be around 40–60 per cent (Neuberger & Price, 2003). As each centre that has developed an LDLT programme has had their own individual reporting methods, it is difficult to establish exact figures – a complication in one hospital may not have been noted as such in another.

The risks of adult LDLT were highlighted in 2002 following the death of the journalist Mike Hurowitz at Mount Sinai Hospital in New York. Hurowitz died three days after donating part of his liver to his brother. The LDLT programme at Mount Sinai was suspended for two years and a committee was set up to review the adult living liver donation programme in New York. This review resulted in the recommendation of a donor advocate team (DAT) for each potential donor, in all centres undertaking LDLT.

The SLTU has acted upon this recommendation and will employ a DAT to assess each potential donor. Initially, the Scottish DAT will consist of a consultant physician, a consultant liaison psychiatrist, a transplant social worker and a transplant coordinator. Team members will have no involvement with the potential recipient in order to ensure that their concern is solely with the donor. Psychologists are often members of DATs, and in Scotland, psychologists will play a key role in evaluating the LDLT programme. The plan is for a psychological research programme to: (a) evaluate donors and recipients pre- and post-transplant, focusing on affective

status, functional capacity, quality of life, neuropsychological status, illness perceptions and family relationships, and (b) carry out a detailed qualitative evaluation of donors and recipients, assessing their perceptions and experience of the assessment, the decision-making process and experience of LDLT.

The role of the DAT is to ensure that the donor's well-being is given priority during the whole transplant process. The DAT arranges for each potential donor to have a full medical and psychosocial assessment, to confirm that they are suitable for donation. For example, the donor and patient's blood type must be compatible, and the donor must have no underlying significant medical problems. Such problems would only serve to increase the risk of the operation. The DAT will also assess whether the donor is acting under any undue financial or emotional pressure to donate. There are no guarantees that the operation will be a success; the recipient may reject the donated segment of liver or may not survive the operation. It is crucial that any potential donor fully understands the risks and benefits involved before going ahead with the operation. The DAT will aim to ensure that this is achieved, and will offer the donor support and advice up to and following the transplant operation.

Many potential donors may not be considered suitable for LDLT for medical or psychological reasons. An appreciation of the risks involved for the donor may act as a deterrent for either the donor or for the patient due to receive the donated liver. The patient needs to be willing to accept the risks involved for their donating relative. In addition, at this early stage of the LDLT programme, the operation will only be available to patients suffering from chronic liver disease. Patients in acute liver failure often only have a few days to live, which is not enough time for the necessary in-depth assessment of donors to be carried out.

## Research issues

LDLT with adults has only been available for around 10 years and only in a select number of countries. Knowledge of the long-term effects of the LDLT operation upon donors is therefore limited – research is vital in order to enable people thinking of becoming a living liver donor to make a fully informed decision.

The LDLT programme highlights a number of key psychological issues where research needs to be focused. Some psychological studies have been carried out in the countries that currently offer LDLT, but the majority have small sample sizes and have looked predominantly at the donor's quality of life following LDLT (e.g. Miyagi *et al*., 2005). Encouragingly, the donor's quality of life following the operation is usually reported to be as good as, or better than, the average for the general population. However, LDLT with adults poses a number of psychological questions that go beyond the donor's quality of life and have not yet been properly investigated (see box).

There are also cognitive issues. Patients with serious liver disease often have a degree of cognitive impairment (hepatic encephalopathy) because the liver cannot adequately carry out its function of breaking down the products of digestion. As a result toxins build up in the blood stream and have a detrimental effect on all organs, including the brain. Memory impairment and psychomotor slowing are common (O'Carroll *et al*., 1991). In a Scottish study of patients pre- and post-liver transplant (from non-living donors), memory impairment and marked slowing of reaction times were commonly observed before transplantation. One year following transplantation, cognitive functioning had improved significantly, but remained below the level of healthy participants (O'Carroll *et al*., 2003). In LDLT an adult patient needs a large part (60 per cent) of the donor's liver to be transplanted into them, leaving the donor with only a small section (40 per cent) of their liver. The liver starts to grow again immediately after the transplant operation but can take about one year to return to its original size. Will this small lobe of the liver be sufficient to fully remove all toxins from the blood? How will this period of reduced liver mass affect the cognitive status, functional capacity and quality of life of the recovering donor?

## KEY RESEARCH QUESTIONS

- How well do members of the general public understand and assess relative risk?
- How does emotion impact upon the decision-making processes?
- How do donors evaluate their role and how does this influence their recovery after surgery?
- How will the potential donor react when told they are unsuitable for donation, and how will this affect their relationship with their relative in need of the transplant and other family members?
- How are such relationships affected when the potential donor decides the risks are too high and chooses not to proceed?

Questions regarding the psychological impact of LDLT upon the recipient also need to be answered, such as:

- How will the recipient react to a decision of donor unsuitability?
- How will the recipient cope if their donor becomes very ill or dies as a result of the operation?

## Only an alternative

LDLT is a good example of the kind of advance that has been made in medical and surgical procedures over recent years. However, it also highlights a host of key psychological issues that are central to such developments. High-quality research is urgently required.

Although LDLT does offer hope to patients on the liver transplant waiting list, it must be emphasised that LDLT is only an alternative to non-living donations and not a replacement. A liver from someone who has died remains the preferred option. LDLT will not cause the waiting-list problem to completely disappear; there is still an urgent need for people to agree to the donation of their organs after their death. Adding your name to the donor register and telling your friends and family that you wish to help someone live after you have gone is the best current solution to the problem. Why not discuss your intentions with friends and family and sign up now? See *www.uktransplant.org.uk/ukt*.

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